HPHC Insurance Company

# Benefit Handbook

## PPO ACCESS HSA FOR INDIVIDUAL MEMBERS
## *MASSACHUSETTS*

This Benefit Handbook is the legal document that defines the relationship between Members and HPHC Insurance Company, Inc. (HPHC). It describes benefits, limitations, conditions, exclusions, and other important information relevant to Members enrolled in this health plan.

In exchange for premiums paid in advance, HPHC agrees to provide or arrange for health care services to enrolled Members, subject to all the terms of this Handbook for the period the premium covers. By signing and returning the membership Enrollment Form, and/or by paying any applicable premiums, the Subscriber applies for membership in the Plan and agrees to all the terms of this Handbook.

**EFFECTIVE DATE:** 01/01/2025
**FORM #**1141_23

# INTRODUCTION

Welcome to the PPO Access HSA for Individual Members (the Plan) offered by HPHC Insurance Company, Inc. (HPHC). Thank you for choosing us to help meet your health care needs.

The Plan is designed to meet Internal Revenue Service rules for a "High Deductible Health Plan." You may be eligible for a Health Savings Account (HSA). An HSA may be used to pay for:

- Member Cost Sharing for Covered Benefits; and
- Some health care services that are not covered by the Plan.

An HSA may also provide tax advantages. Please consult a qualified tax advisor. He or she can advise if you are eligible for an HSA and how it works.

The words "we," "us," and "our" used in this Handbook, refer to HPHC. The words "you" or "your" used in this handbook refer to Members as defined in the Glossary.

To use the Plan effectively, you must review this Handbook and the Schedule of Benefits together. They describe your In-Network, and Out-of-Network benefits. This Plan is designed to allow you to obtain Covered Benefits through the Plan's network of Plan Providers or the Non-Plan Provider of your choice. Benefits are covered both In-Network and Out-of-Network. Your In-Network benefits provide you with a higher level of coverage at a lower out-of-pocket cost.

All In-Network care must be provided by Plan Providers, except care needed in a Medical Emergency.

Covered Benefits received from a Non-Plan Provider are covered at the Out-of-Network level.

Some benefits have limits on the amount of coverage provided in a Plan Year or Calendar Year. Please see your Schedule of Benefits to determine which type of year your Plan utilizes. When a benefit has a limit, In-Network and Out-of-Network services will usually be combined and count together against the limit. Please see your Schedule of Benefits for detailed information regarding benefit limits on your coverage.

Your Covered Benefits are described in this Handbook, the Schedule of Benefits, the Prescription Drug Brochure and any riders or amendments.

The Plan will provide premium information about HPHC's voluntary and involuntary disenrollment rate as required by Massachusetts law. This information will be sent to you in a separate letter. Please keep that letter with this Handbook.

We provide a wide range of helpful online tools at **www.harvardpilgrim.org**.

**Your secure online account** offers a safe way to help manage your health care. You can check your Schedule of Benefits and Benefit Handbook. You can look up:

- benefits,
- cost sharing,
- claims history,

- Deductible status,
- view Prior Approvals and referrals.

You can also learn how your Plan covers preventive care and conditions such as asthma, diabetes, COPD and high blood pressure.

You can use the cost transparency tool to compare cost and quality on many types of services, including surgical procedures and office visits. This tool provides estimated costs only. Your Member Cost Sharing may be different.

To use the tools and resources online, visit **www.harvardpilgrim.org** and select the Member Login button. First time users must create an account and then log in. After you log in, click on the "Tools and Resources" link from your Member dashboard. Look for the Estimate My Cost link to get to the cost transparency tool.

When you receive Covered Benefits under the Plan, you will receive an Activity Statement. This is also known as a Summary of Payment. The Activity Statement lists the Covered Benefits, the cost for those Covered Benefits, and your Member Cost Sharing. You have the right to ask that your Activity Statement be sent to you. It may be sent to a specific mailing address, or electronically through your secure online account, or be sent to an authorized third party on your behalf. In some instances, you may also request that we not send an Activity Statement for a specific service. You may contact Member Services to make these requests.

For any questions, call Member Services at **1-877-907-4742** if you have any questions. Member Services staff can help you with questions about the following:

- Selecting Plan Providers;
- Your Benefit Handbook;
- Your In-Network and Out-of-Network benefits;
- Your enrollment;
- Your claims;
- Pharmacy management procedures;
- Provider information;
- Requesting a Provider Directory;
- Requesting a Member Kit; and
- Requesting ID cards;
- Registering a complaint

We can help with questions from non-English speaking Members. We offer language interpretation services in more than 180 languages.

Deaf and hard-of-hearing Members may call **711** for TTY service.

We value your input. We appreciate any comments or ideas that will help us improve the quality of our services.

**HPHC Insurance Company, Inc.**
**Member Services Department**
**1 Wellness Way**
**Canton, MA 02021**
**Phone: 1-877-907-4742**
**www.harvardpilgrim.org**

**The Office of Patient Protection.** The Office of Patient Protection is part of the Health Policy Commission. This group makes sure the Massachusetts laws about managed care complaint rights are followed. They are also in charge of directing appeals to outside review groups. You can reach them at:

**Health Policy Commission**
**Office of Patient Protection**
**50 Milk Street, 8th Floor**
**Boston, MA 02109**
**Telephone: 1-800-436-7757**
**Fax: 1-617-624-5046**
**HPC-OPP@state.ma.us**
**http://www.masshpc.gov/OPP**

The Office of Patient Protection can provide you with information. This includes:

- A list of published information that assesses how well Subscribers like their plan;
- The percentage of doctors who cancel their contracts with the plan during the previous calendar year for which such data has been compiled and the three most common reasons for physician disenrollment;
- The percentage of premium returns spent by the plan on health care services given; and
- A report from the prior calendar year that gives data about the number of complaints a plan receives and how they are resolved.

**Commonwealth Health Insurance Connector Authority (Connector).** The independent public authority created to implement portions of the Massachusetts Health Care Reform Law. For more information, the Connector can be reached at:

Commonwealth Health Insurance Connector Authority 100 City Hall Plaza, Boston, MA 02108,
**Telephone: 1–877–623–6765**
**website: http://www.mahealthconnector.org**

**Medical Necessity Guidelines.** We use evidence based clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for your care. To get Medical Necessity Guidelines, you or your Provider may call Member Services at **1-877-907-4742** or go to **www.harvardpilgrim.org**.

**Exclusions or Limitations for Preexisting Conditions.** The Plan has no pre-existing condition restrictions, limitations or exclusions.

When you enroll in the Plan, you have ten (10) days to look over the Handbook and decide whether you want to remain enrolled in this Plan. If you decide that the Plan is not the right choice for you, you may disenroll. You must disenroll within the first ten (10) days of enrollment. HPHC will send back your premium to you as long as no medical services have been received by any Member under this Plan. To disenroll, you must

notify HPHC in writing. The envelope must be postmarked within ten (10) days of the effective date of this Plan.

THIS PLAN IS NOT A MEDICARE SUPPLEMENT PLAN. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from HPHC.

## Language Assistance Services

**Español (Spanish)** ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están a su disposición. Llame al 1-888-333-4742 (TTY: 711).

**Português (Portuguese)** ATENÇÃO: Se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-888-333-4742 (TTY: 711).

**Kreyòl Ayisyen (French Creole)** ATANSYON: Si nou palé Kreyòl Ayisyen, gen asistans pou sèvis ki disponib nan lang nou pou gratis. Rele 1-888-333-4742 (TTY: 711).

**繁體中文 (Traditional Chinese)** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-333-4742（TTY：711）。

**Tiếng Việt (Vietnamese)** CHÚ Ý: Nếu quí vị nói Tiếng Việt, dịch vụ thông dịch của chúng tôi sẵn sàng phục vụ quí vị miễn phí. Gọi số 1-888-333-4742 (TTY: 711).

**Русский (Russian)** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-333-4742 (телетайп: 711).

**العربية (Arabic)**
**إنتباه:** إذا أنت تتكلم اللُّغة **العربية** ، خدمات المساعدة اللُّغوية متوفرة لك مجانا. **إتصل على 1 888-333-4742**
(TTY: 711)

**ខ្មែរ (Cambodian)** ប្រសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាកម្មបកប្រែ ជូនលោកអ្នកដោយ គិតថ្លៃ។ ចូរ ទូរស័ព្ទ 1-888-333-4742 (TTY: 711)។

**Français (French)** ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-333-4742 (ATS: 711).

**Italiano (Italian)** ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-333-4742 (TTY: 711).

**한국어 (Korean)** '알림': 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-333-4742 (TTY: 711) 번으로 전화해 주십시오.

**Ελληνικά (Greek)** ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχουν στη διάθεσή σας δωρεάν υπηρεσίες γλωσσικής υποστήριξης. Καλέστε 1-888-333-4742 (TTY: 711).

**Polski (Polish)** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-333-4742 (TTY: 711).

**हिंदी (Hindi)** ध्यान दीजिए: अगर आप हिंदी बोलते हैं तो आपके लिये भाषाकी सहायता मुफ्त में उपलब्ध है. जानकारी के लिये फोन करे. 1-888-333-4742 (TTY: 711)

**ગુજરાતી (Gujarati)** ધ્યાન આપો : જો તમે ગુજરાતી બોલતા હો તો આપને માટે ભાષાકીય સહાય તદ્દન મફત ઉપલબ્ધ છે. વિશેષ માહિતી માટે ફોન કરો. 1-888-333-4742 (TTY: 711)

**ພາສາລາວ (Lao)** ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-333-4742 (TTY: 711).

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-888-333-4742 (TTY: 711).

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

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**General Notice About Nondiscrimination and Accessibility Requirements**

Harvard Pilgrim Health Care and its affiliates as noted below ("HPHC") comply with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).

HPHC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters.

If you need these services, contact our Civil Rights Compliance Officer.

If you believe that HPHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity), you can file a grievance with: Civil Rights Compliance Officer, 1 Wellness Way, Canton, MA 02021-1166, (866) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: civil_rights@point32health.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019, (800) 537-7697 (TTY)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

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# TABLE OF CONTENTS

## Benefit Handbook

# I. How the Plan Works

The Plan provides you with two levels of benefits known as In-Network and Out-of-Network coverage.

This section describes:

- how to use your Benefit Handbook.
- how your coverage works.

## A. HOW TO USE THIS BENEFIT HANDBOOK

### 1. Why This Benefit Handbook Is Important

This Benefit Handbook, the Schedule of Benefits, the Prescription Drug Brochure and applicable riders and amendments make up the Evidence of Coverage (EOC). The EOC is the legal agreement stating the terms of the Plan.

The Benefit Handbook describes how your Plan works. It's also your guide to the most important things you need to know, including:

- How to obtain benefits with the lowest out-of-pocket cost
- Covered Benefits
- Exclusions
- The requirements for In-Network and Out-of-Network coverage

You can view your EOC documents online by using **your secure online account** at **www.harvardpilgrim.org**.

### 2. Words With Special Meaning

Some words in this Handbook have a special meaning. These words are capitalized and are defined in the *Glossary*.

### 3. How To Find What You Need To Know

This Handbook's Table of Contents will help you find the information you need. The following describes some important sections of the Handbook.

We put the most important information first. For example, *I. How the Plan Works* explains important requirements for coverage.

Benefit details are described in section *III. Covered Benefits* and in your Schedule of Benefits. Please review these together for a complete understanding of your benefits.

*VI. Appeals and Complaints* provides detailed information on how to appeal a denial of coverage or file a complaint.

## B. HOW TO USE YOUR PROVIDER DIRECTORY

The Provider Directory lists the Plan Providers you must use for In-Network Benefits. You may view the Provider Directory online at our website, **www.harvardpilgrim.org**. You can also get a paper copy, free of charge. Call Member Services at **1-877-907-4742** to get a copy.

The online Provider Directory enables you to search for Providers. You can search by:

- name,
- gender,
- specialty,
- hospital affiliations,
- languages spoken, and
- office locations.

You can get information about which Providers are accepting new patients. The online directory complies with state and Federal laws. It is more current than the paper directory.

A physician profiling site is maintained by the Commonwealth of Massachusetts Board of Registration in Medicine. You may access this site at **www.mass.gov/orgs/board-of-registration-in-medicine**.

**Please Note:** Providers in the Plan's provider network participate through contractual arrangements. Contracts can be terminated either by a Provider or by us. A Plan Provider may also leave the network to retire, relocate or for other reasons. This means that we cannot guarantee your Plan Provider will be in the network for the duration of your membership.

## C. MEMBER OBLIGATIONS

### 1. Show Your Identification Card

You should show your identification (ID) card every time you request health services. If you do not show your ID card, the Provider may not bill us for Covered Benefits. You may be responsible for the cost of the service. You can order a new ID card online. Go to **your secure online account** at **www.harvardpilgrim.org** or call Member Services.

### 2. Share Costs

You must share the cost of Covered Benefits provided under the Plan. Your Member Cost Sharing may include one or more of the following:

- Copayments
- Coinsurance
- Deductibles

Your Plan also has an Out-of-Pocket Maximum. This limits the amount of Member Cost Sharing you will be required to pay. Your specific Member Cost Sharing is listed in your Schedule of Benefits. See section *I.E. MEMBER COST SHARING* for more information.

**3. Obtain Prior Approval**
You must obtain Prior Approval before receiving certain Covered Benefits. Please see section *I.F. PRIOR APPROVAL* for more information.

**4. Your Plan Does Not Pay for All Health Services**
There may be health products or services you need that are not covered by the Plan. Please review section *IV. Exclusions* for more information. In addition, some services that are covered by the Plan are limited. These limits are needed to maintain reasonable premium rates for all Members. Please see your Schedule of Benefits for the limits that apply to your Plan.

## D. HOW TO OBTAIN CARE

**IMPORTANT POINTS TO REMEMBER**

1) The Plan has two levels of benefit coverage known as In-Network benefits and Out-of-Network benefits.
2) In-Network benefits are available for Covered Benefits received from Plan Providers.
3) Plan Providers are under contract with HPHC to provide services to Members.
4) Out-of-Network benefits are available for Covered Benefits received from Non-Plan Providers.
5) Some services require Prior Approval by the Plan.
6) In the event of a Medical Emergency, go to the nearest emergency facility or call 911 or other local emergency number.

**1. How Your In-Network Benefits Work**
In-Network benefits apply when you receive Covered Benefits from a Plan Provider. Your Member Cost Sharing is generally lower for In-Network benefits. In-Network coverage applies to Plan Providers in Massachusetts, Maine, New Hampshire, Rhode Island and Vermont. In-Network benefits also apply to large number of Providers in HPHC's affiliated national network around the country. We pay Plan Providers directly. You do not have to file a claim when you use your In-Network benefits.

Plan Providers are under contract to provide Covered Benefits to Members. They are listed in the Plan Provider Directory. Every effort is made to keep the Provider Directory up-to-date. However, changes may occur for a number of reasons. Members can call Member Services at **1-877-907-4742** to confirm a Provider's status. Members should present their ID card to a Provider before receiving services.

When obtaining In-Network benefits, some services require Prior Approval by the Plan. Please see section *I.F. PRIOR APPROVAL* for information on the Prior Approval Program.

**Please Note:** In Massachusetts, Maine, New Hampshire and Rhode Island, some specialized services must be received from a "Center of Excellence" to receive In-Network coverage. Please see section *I.D.5. Centers of Excellence* for more information.

**2. How Your Out-of-Network Benefits Work**
Out-of-Network Benefits are available when you receive Covered Benefits from Non-Plan Providers. The Plan pays only a percentage of the cost of Covered Benefits received from Non-Plan Providers. You must pay the balance. Your Member Cost Sharing is generally higher for Out-of-Network benefits. However, you may go to the licensed health care professional of your choice.

Some services require Prior Approval by the Plan. Please see section *I.F. PRIOR APPROVAL* for more information.

Payments to Plan Providers are based on a contracted rate between us and the Plan Provider. As Non-Plan Providers are not contracted, there is no limit on the amount they can charge. The Plan will pay up to the Allowed Amount for a Covered Benefit. You must pay any charges above the Allowed Amount for the service, unless it is a Surprise Bill. See section *V. Reimbursement and Claims Procedures* for more information.

**3. Selecting a Plan Provider**
To use In-Network benefits you must receive services from a Plan Provider. You may use the Provider Directory to find Plan Providers. The Provider Directory identifies the Plan's participating specialists, hospitals and other Providers.

If you have difficulty finding a Plan Provider who can provide the services you need, we will help you. For help finding a medical, mental health or substance

use disorder treatment Provider, please call Member Services at **1-877-907-4742.** If no Plan Provider has the expertise needed to provide the Medically Necessary Covered Benefit, we will help you find an appropriate Non-Plan Provider.

**4. Flex Providers**
Some Plans include Flex Providers. A Flex Provider is a Plan Provider that provides certain outpatient services with lower Member Cost Sharing. Your costs will be lower if you choose to go to a Flex Provider for these services.

✔ FOR EXAMPLE: An example of a Covered Benefit that may be available through a Flex Provider is outpatient surgery. If your Plan includes Flex Providers and you go to an outpatient surgical center designated as a Flex Provider, your Member Cost Sharing will be less than if you went to a hospital surgical center that is not a Flex Provider.

Your Schedule of Benefits will indicate if your Plan includes Flex Providers, It will list the Member Cost Sharing amounts for both Plan Providers and Flex Providers under the applicable Covered Benefits.

Your Provider Directory will list Flex Providers if these Providers are included under your Plan. For a complete list of Plan Providers, see your Provider Directory which may be found at **www.harvardpilgrim.org**.

**5. Centers of Excellence**
Plan Providers with special training, experience, facilities or protocols for certain specialized services are designated as "Centers of Excellence."

We choose Centers of Excellence based on the findings of recognized specialty organizations or government agencies such as Medicare. Centers of Excellence are located in Massachusetts, Maine, New Hampshire and Rhode Island. To receive In-Network coverage in these states, you must obtain care at a Center of Excellence for the following service(s):

- Weight loss surgery (bariatric surgery)

**Important Notice:** If you choose to receive care in MA, ME, NH or RI, for the above services at a facility other than a contracted Center of Excellence, coverage will be at the Out-of-Network benefit level.

To receive In-Network benefits for the services listed above outside of MA, ME, NH or RI, you must obtain care at a hospital that is listed as a Plan Provider. See your Provider Directory for a list of participating hospitals.

If you chose to receive care for the above services at a facility other than a Plan Provider, coverage will be at the Out-of-Network benefit level.

A list of Centers of Excellence may be found in the Provider Directory. See your Provider Directory online at **www.harvardpilgrim.org** or call Member Services at **1-877-907-4742.**

Services or procedures may be added to or removed from the list with 30 days' notice to Members. We may:

- add services to the list if significant improvements in the quality of care may be obtained through the use of selected Providers.
- remove services from the list if we determine the care advantages through the use of a specialized panel of Providers no longer exists.

**6. Covered Benefits from Our Affiliated National Network of Providers**
HPHC offers a comprehensive network of Plan Providers located in Massachusetts, New Hampshire, Rhode Island, Vermont or Maine. In addition, HPHC's national provider network allows Members to use In-Network benefits outside of those states. As of the date on this Handbook, the national network includes nearly 1.1 million Plan Providers and over 4,500 hospitals. To locate one of these Providers, go to **www.harvardpilgrim.org** or call Member Services at **1-877-907-4742.**

**7. How to get Care After Hours**
Either your doctor or a covering Provider is available to direct your care 24-hours a day. Talk to your doctor to find out what to do for care needed after normal business hours. Some doctors may have covering physicians after hours. Others may have extended office/clinic hours. In a Medical Emergency, go to the nearest emergency facility or call 911 or other local emergency number.

**8. Medical Emergency Services**
In a Medical Emergency, including an emergency related to a substance use disorder or mental health

condition, go to the nearest emergency facility or call 911 (or other local emergency number). This includes an emergency due to a substance use disorder or mental condition. See your Schedule of Benefits for your Member Cost Sharing. If you are admitted to the hospital, you must call the Plan at **1-877-907-4742** within 48 hours or as soon as you can. This telephone number is also on your ID card. If an attending emergency physician contacts us or your PCP, then no further notice is needed. See the *Glossary* for additional information on Medical Emergency Services.

## E. MEMBER COST SHARING

In-Network and Out-of-Network Member Cost Sharing may include Copayments, Coinsurance and/or Deductible amounts. There may be two types of office visit cost sharing that apply to your Plan:

- a lower cost sharing known as "Level 1" and
- a higher cost sharing known as "Level 2."

See your Schedule of benefits for the Member Cost Sharing See your Schedule of benefits for the .

**Please Note:** If you receive a Surprise Bill, you are only responsible for the applicable Member Cost Sharing that would apply if the covered service was provided by a Plan Provider, unless you had a reasonable opportunity to choose to have the service performed by a Plan Provider.

### 1. Copayment

A Copayment is a fixed dollar amount you must pay for certain Covered Benefits. Copayments are due at the time of service or when billed by the provider.

Your Plan may have other Copayment amounts. See your Schedule of Benefits for more information on your specific Copayments.

### 2. Deductible

A Deductible is a specific dollar amount that is paid by the Member for Covered Benefits received each Plan Year or Calendar Year. Please see your Schedule of Benefits to see which type of year applies to your Plan.

A Deductible is applied:

- before any benefits subject to the Deductible are paid by the Plan.
- on the date the benefit is received.

Your Plan will have one of the following types of Deductibles:

**Individual Deductible.** An individual Deductible will apply when you have Individual Coverage. Once you have met the individual Deductible, you will have no additional Deductible costs for the rest of the Plan Year or Calendar Year. Note: An individual Deductible may also apply if you have Family Coverage. See Family Deductible with an embedded individual Deductible below.

**Family Deductible.** A family Deductible applies when you have Family Coverage. This Deductible may be met by all family Members combined. For example, a family of four would meets a $4,000 family Deductible as follows:

- one covered family Member incurs $3,000 in covered medical expenses, and
- another covered family Member incurs $1,000 in covered medical expenses.

In this example, the family Deductible is met for the entire family for the rest of that Plan Year or Calendar Year.

**Family Deductible with an embedded individual Deductible.** A family Deductible with an embedded individual Deductible applies when you have Family Coverage. This Deductible can be met in one of two ways:

a. A Member of a covered family meets an individual Deductible. In this instance, that Member has no additional Deductible costs for the rest of the Plan Year or Calendar Year.

b. Any number of Members in a covered family collectively meet the family Deductible. In this instance, all Members of a covered family have no additional Deductible costs for the rest of the Plan Year or Calendar Year. No one family member may contribute more than the individual Deductible amount to the family Deductible.

An embedded individual Deductible cannot be less than the minimum family Deductible required for a High Deductible Health Plan.

Please see your Schedule of Benefits to determine which Deductibles apply to your Plan.

Once a Deductible is met, coverage by the Plan is subject to any other Member Cost Sharing that may apply.

A Member may change from Family Coverage to Individual Coverage or from Individual Coverage to Family Coverage within a Plan Year or Calendar Year. In either case, costs the Member paid toward the Deductible under the prior coverage will apply toward the Deductible limit under their new coverage. If the

previously paid Deductible amount is more than the new Deductible limit, the Member or family will only need to pay the Copayment or Coinsurance amounts listed in on their new Schedule of Benefits.

### 3. Coinsurance

After your Deductible is met, you may have to pay Coinsurance. Coinsurance is a percentage of the Allowed Amount or the Recognized Amount, if applicable. For Plan Providers, the Allowed Amount is based on the contracted rate between HPHC and the Provider. For Non-Plan Providers, the Allowed Amount is based on the Provider's charge for the service up to the Allowed Amount for the service. In most cases higher Coinsurance amounts will apply to Out-of-Network services. Coinsurance amounts are listed on your Schedule of Benefits.

### 4. Out-of-Pocket Maximum

Your Plan has an Out-of-Pocket Maximum. This is the total amount of Member Cost Sharing you must pay in a Plan Year or Calendar Year. Member Cost Sharing includes any Copayments, Deductible and Coinsurance payments.

Once the Out-of-Pocket Maximum is reached, there is no additional Member Cost Sharing for the rest of the year. HPHC will pay 100% of the Allowed Amount for the remainder of the Plan Year or Calendar Year.

Certain costs do not apply to the Out-of-Pocket Maximum. Penalty amounts and charges above the Allowed Amount never apply to the Out-of-Pocket Maximum.

**Individual Out-of-Pocket Maximum.** An individual Out-of-Pocket Maximum applies when you have Individual Coverage. Once you meet the individual Out-of-Pocket Maximum, you will have no additional Member Cost Sharing for the rest of the Plan Year or Calendar Year. Note: An individual Out-of-Pocket Maximum may also apply if you have Family Coverage. See Family Out-of-Pocket Maximum with an embedded individual Out-of-Pocket Maximum below.

**Family Out-of Pocket Maximum.** A family Out-of-Pocket Maximum applies when you have Family Coverage. A family Out-of-Pocket Maximum can be met by all Members of the family combined. For example, a family of four meets a $10,000 family Out-of-Pocket Maximum as follows:

- one covered family Member pays $5,000 in Member Cost Sharing; and
- another family Member pays $3,000 in Member Cost Sharing; and
- another covered family Member pays $2,000 in Member Cost sharing.

In this example, the $10,000 family Out-of-Pocket Maximum is met for the entire family for the rest of the Plan Year or Calendar Year.

**Family Out-of-Pocket Maximum with an embedded individual Out-of-Pocket Maximum.** This family Out-of-Pocket Maximum may apply when you have Family Coverage. It can be met in one of two ways:

a. A Member of a covered family meets an individual Out-of-Pocket Maximum. In this case, the Member has no additional Member Cost Sharing for the rest of the Plan Year or Calendar Year.

b. Any number of Members in a covered family collectively meet the family Out-of-Pocket Maximum. In this case, all Members of the covered family have no additional Member Cost Sharing for the rest of the Plan Year or Calendar Year. Note: No one family member may contribute more than the individual Out-of-Pocket Maximum amount toward the family Out-of-Pocket Maximum.

Please see your Schedule of Benefits to determine which Out-of-Pocket Maximum applies to your Plan.

A Member may change from Family Coverage to Individual Coverage or from Individual Coverage to Family Coverage within a Plan Year or Calendar Year. In either case, costs the Member paid under the prior coverage will apply toward the Out-of-Pocket Maximum limit under their new coverage. If the Out-of-Pocket Maximum amount paid is greater than the new Out-of-Pocket Maximum limit, the Member will have no additional Member Cost Sharing for that Plan Year or Calendar Year.

### 5. Out-of-Network Charges in Excess of the Allowed Amount

On occasion, a Non-Plan Provider may charge more than the Allowed Amount covered by the Plan. You must pay the difference between what the Provider charges and the amount the Plan paid, unless it is a Surprise Bill. Amounts charged by a Non-Plan Provider above the Allowed Amount do not count toward the Out-of-Pocket Maximum. Call Member Services at **1-877-907-4742** or at **711** for TTY service. They can answer questions about the maximum Allowed Amount that may be paid by

HPHC for a service. See section *V. Reimbursement and Claims Procedures* for more information.

### 6. Penalty

The amount you must pay for certain Out-of-Network medical services or Medical Drugs when Prior Approval was not obtained before receiving the services. The Penalty charge is in addition to any Member Cost Sharing amounts. Penalty charges do not count towards any Out-of-Pocket Maximum. Please see section *I.F. PRIOR APPROVAL* for a detailed explanation of the Prior Approval program.

### 7. Combined Payment Levels

Under some circumstances you may choose to receive services from both a Plan Provider and a Non-Plan Provider. Use of In-Network or Out-of-Network coverage always depends upon the participation status of the individual service Provider. For example, you can receive treatment in a Plan Provider's office, then choose to go to a non-plan laboratory to receive blood work. As payment level depends upon the participation of the Provider, the Plan Provider will be paid at the In-Network coverage level. The laboratory would be paid at the Out-of-Network coverage level.

The benefit payment level applied to a hospital admission depends on the participation of both the admitting doctor and the hospital. If a Plan Provider admits you to a participating hospital, both the hospital and Plan Provider are paid at the In-Network level. If an Out-of-Network doctor admits you to a participating hospital, the hospital is paid at the In-Network level but the doctor's charges are paid at the Out-of-Network level. Likewise, if a Plan Provider admits you to a non-plan hospital, the hospital's charges are paid at the Out-of-Network level but the Plan Provider's charges are paid at the In-Network level. All Out-of-Network payments by the Plan are limited to the Allowed Amount.

## F. PRIOR APPROVAL

Prior Approval must be obtained before receiving certain medical services, Medical Drugs or mental health and substance use disorder treatment.

If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. If you use a Non-Plan Provider or Plan Provider outside the Service Area, you must seek Prior Approval. This section explains when Prior Approval is required and how to meet those requirements.

**Important Notice: For a detailed list of services that require Prior Approval or for updates and revisions to the Prior Approval list, please visit our website at www.harvardpilgrim.org**. If you have questions regarding services that require Prior Approval, contact Member Services at **1-877-907-4742**.

**Please Note:** Your doctor or hospital can seek Prior Approval on your behalf. Also, you do not need to obtain Prior Approval if services are needed in a Medical Emergency.

### 1. When Prior Approval is Required

Prior Approval must be obtained for the services listed below.

1) **For Substance Use Disorder Treatment from a Provider not certified or licensed by the Massachusetts Department of Public Health** Prior Approval must be obtained before receiving substance use disorder treatment from a Provider not certified or licensed by the Massachusetts Department of Public Health (i.e. Providers located outside the Commonwealth of Massachusetts).

   **Please Note:** Prior Approval is not required to obtain Acute Treatment Services or Clinical Stabilization Services from either a Plan Provider or Non-Plan Provider. The terms "Acute Treatment Services" and "Clinical Stabilization Services" are defined in the Glossary at Section II of this Benefit Handbook. Services beyond the 14 day period may be subject to concurrent review as described in Section *XI.L. UTILIZATION REVIEW PROCEDURES* of this Handbook.

2) **For the following Mental Health Treatment obtained from a Non-Plan Provider or Plan Provider Outside the Service Area:**
   - **In-home behavioral services (IHBS)**
   - **In-home therapy (IHT)**
   - **Psychological testing and Neuropsychological testing**
   - **Applied Behavioral Analysis (ABA) services for the treatment of Autism**
   - **Repetitive Transcranial Magnetic Stimulation (rTMS)**

   **For a detailed list of services that require Prior Approval or for updates and revisions to the Prior Approval list, please visit our website at www.harvardpilgrim.org**. If you

have questions regarding services that require Prior Approval, please contact Member Services at **1-877-907-4742**.

3) **For the following Medical Services or Medical Drugs obtained from a Non-Plan Provider or Plan Provider Outside the Service Area:**
   - **Inpatient services**
   - **Outpatient services and treatments** including but not limited to: infertility treatment; genetic testing; home health care; advanced radiology; and pain management.
   - **Outpatient surgery**
   - **Medical Drugs**
   - Medical formulas
   - **Diabetic equipment**
   - **Non-emergency medical transportation** Please note, Prior Approval is not required for transportation provided by a wheelchair van.
   - **Positive airway pressure devices, including CPAP and BIPAP devices**
   - Power wheelchairs
   - **Prosthetic arms and legs**
   - **Dental services** Please note, the Plan provides very limited coverage for Dental Care. (Please see "Dental Services" in section III. Covered Benefits and your Schedule of Benefits for details.)

**Please Note:** Not all plans cover every service listed on the Prior Approval List. Please see your Schedule of Benefits to determine if your Plan provides coverage for a specific benefit or call Member Services at **1-877-907-4742**.

### 2. How to Obtain Prior Approval

To seek Prior Approval for services received from a Non-Plan Provider or a Plan Provider outside the Service Area, you should call:

- **1-800-708-4414** for medical services
- **1-877-907-4742** for Medical Drugs
- **1-800-708-4414** for mental health and substance use disorder treatment

The following information must be given when seeking Prior Approval for medical services or Medical Drugs:

- The Member's name
- The Member's ID number
- The treating physician's name, address and telephone number
- The diagnosis for which care is ordered
- The treatment ordered and the date it is expected to be performed

For inpatient admission to a Non-Plan Provider or a Plan Provider outside the Service Area, the following additional information must be given:

- The name and address of the facility where care will be received
- The admitting physician's name, address and telephone number
- The admitting diagnoses and date of admission
- The name of any procedure to be performed and the date it is expected to be performed

### 3. The Effect of Prior Approval on Coverage

If you obtain Prior Approval when required, the Plan covers up to the full benefit limit stated in this Benefit Handbook and your Schedule of Benefits.

If you do not obtain Prior Approval when required, the Plan covers only the services later determined to be Medically Necessary. You will be responsible for any applicable Member Cost Sharing. For medical services or Medical Drugs received from a Non-Plan Provider, you must also pay the Penalty amount stated in the Schedule of Benefits.

If HPHC determines at any point that a service is not Medically Necessary, no coverage will be provided for the services at issue, and you must also pay the entire cost of those services.

Please see section *X.XI.L. UTILIZATION REVIEW PROCEDURES* for information on the time limits for Prior Approval decisions and reconsideration procedures for Providers if coverage is denied. Please see Section *VI. Appeals and Complaints* for a description of your appeal rights if coverage for a service is denied by HPHC.

### 4. What Prior Approval Does

The Prior Approval program may do different things depending upon the service in question. These may include:

- Assuring that the proposed service will be covered by the Plan.
- Assuring that benefits are being administered correctly.

- Consulting with Providers to provide information and promote the appropriate delivery of care.
- Evaluating whether a service is Medically Necessary, including:
  - the level of care,
  - place of service, and
  - whether it is, and continues to be, provided in an appropriate setting.

If the Prior Approval program conducts a medical review of a service, you and your physician will be notified of HPHC's decision to approve or not to approve the care proposed. If part of the review is related to level of care, place of service or setting, then providing services in a higher level of care will not be considered Medically Necessary when those same services can be safely provided to you in a lower level of care, place of service or setting.

All decisions to deny a medical service will be reviewed by a physician or a qualified clinician in accordance with Medical Necessity Guidelines. Medical Necessity Guidelines are based on a number of sources. These sources include medical policy and clinical guidelines. The relevant Medical Necessity Guidelines are made available to Providers and Members upon request.

If the Prior Approval program denies a coverage request, it will send you a written notice that explains:

- the decision,
- our Provider's right to obtain reconsideration of the decision, and
- your appeal rights.

## G. SERVICES PROVIDED BY A DISENROLLED OR NON-PLAN PROVIDER

### 1. Disenrollment of a Plan Provider

When your Provider is disenrolled as a Plan Provider, we will provide you with written notice. If disenrollment was not related to fraud or quality of care, you may be able to continue to receive In-Network benefits from this Provider. Coverage will be from the disenrollment date or the date of the disenrollment member notice (whichever is later). The terms of this Handbook and your Schedule of Benefits apply. Only the following services are covered:

a. **Active Course of Treatment**

When you are undergoing an active course of treatment for an illness, injury or condition, we may approve additional coverage through the active course of treatment or up to 90 days, (whichever is shorter). An active course of treatment is when you:

- have a "serious and complex condition."
- are undergoing a course of institutional or inpatient care.
- have scheduled nonelective surgery including any related postoperative care.

The term "serious and complex condition" is an acute illness that requires specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or is a chronic illness that is (a) life-threatening, degenerative, potentially disabling, or congenital; and (b) requires specialized medical care over a prolonged period of time.

b. **Pregnancy**

When you are pregnant, you may continue to receive In-Network benefits from your disenrolled Provider. Coverage will be through delivery and up to 6 weeks of postpartum visits immediately following childbirth.

c. **Terminal Illness**

When you have a terminal illness, you may continue to receive In-Network benefits from the disenrolled Provider until death.

### 2. New Membership

If you are a new Member, we will provide In-Network benefits from a physician or nurse practitioner who is not a Plan Provider. The terms of this Handbook and your Schedule of Benefits apply. This will be provided for up to 30 days from your effective date of coverage if:

- Your only coverage option is a choice of plans in which the physician or nurse practitioner is not a participating Provider, and
- The physician or nurse practitioner is providing you with an ongoing course of treatment.

With respect to a Member in her second or third trimester of pregnancy, this provision shall apply to services rendered through the first postpartum visit. With respect to a Member with a Terminal Illness, this provision shall apply to services rendered until death.

### 3. Conditions for Coverage of Services by a Disenrolled or Non-Plan Provider

Services received from a disenrolled or Non-Plan Provider as described above, are only covered when the physician agrees to:

- accept reimbursement from us at the rates applicable prior to notice of disenrollment (or, in the case of a new Member, our applicable rate) as payment in full.
- not to impose Member Cost Sharing in an amount that would exceed the amount that could have been imposed if the he/she had not been disenrolled.
- adhere to the quality assurance standards of the Plan.
- provide us with necessary medical information related to the care provided.
- adhere to our policies and procedures, including obtaining Prior Approval and providing Covered Benefits pursuant to a treatment plan, if any, approved by us.

## H. MEDICAL NECESSITY GUIDELINES

We use evidence based clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for your care. You or your Provider may obtain a copy of the Medical Necessity Guidelines applicable to a service or procedure for which coverage is requested. Medical Necessity Guidelines may be obtained by calling Member Services at **1-877-907-4742** or going to **www.harvardpilgrim.org**.

## I. PROVIDER FEES FOR SPECIAL SERVICES (CONCIERGE SERVICES)

Certain physician practices charge extra fees for special services or amenities. Examples of such special physician services might include:

- telephone access to a physician 24-hours a day.
- waiting room amenities.
- assistance with transportation to medical appointments.
- guaranteed same day or next day appointments when not Medically Necessary.
- providing a physician to accompany a patient to an appointment with a specialist. Such services are not covered by the Plan.

Such services are not covered by the Plan. The Plan does not cover fees for any service not included as a Covered Benefit under your Plan.

In considering arrangements with physicians for special services, you should understand exactly what services are to be provided. You will need to decide if these services are worth the fee you must pay. For example, the Plan does not require Plan Providers to be available by telephone 24-hours a day. However, the Plan does require Plan Primary Care Providers (PCPs) to provide both an answering service that can be contacted 24-hours a day and prompt appointments when Medically Necessary.

## J. BUNDLED PAYMENT ARRANGEMENTS

The Plan may participate in bundled payment arrangements with certain Providers. Under these arrangements, a specific service or treatment is paid for based on a fixed sum for all services you receive. Member Cost Sharing for Covered Benefits under a bundled payment arrangement may be less than if the Covered Benefits were received without the bundled payment arrangement. Please refer to **www.harvardpilgrim.org** or call Member Services at **1-877-907-4742** for a list of Providers with bundled payment arrangements and their corresponding services. We may revise the services or Providers who have bundled payment arrangements upon 30 days notice to Members.

## K. CARE MANAGEMENT PROGRAMS

The Plan provides care management programs for Members with certain illnesses and injuries. These programs are designed to encourage the use of the most appropriate and cost-effective treatment and to provide support for the Member's care.

Care management may include programs for medical and behavioral health care including, but not limited to:

- cancer;
- heart, lung and kidney diseases;
- severe traumatic injuries;
- behavioral health disorders;
- substance use disorders;
- high risk pregnancies and newborn care.

The Plan or Providers affiliated with the care management program may contact Members that may be candidates for its programs. The Plan or Providers may also contact Members to:

- assist with enrollment.
- develop treatment plans.
- establish goals.
- determine alternatives to a member's current treatment plan.

Member Cost Sharing may apply to Covered Benefits provided through a care management program.

# II. Glossary

This section lists words with special meaning within the Handbook.

| Glossary Term | Definition |
|---|---|
| **1 . Activities of Daily Living** | |
| | The basic functions of daily life include bathing, dressing, and mobility, including, but not limited to, transferring from bed to chair and back, walking, sleeping, eating, taking medications and using the toilet. |
| **2 . Acute Treatment Services** | |
| | 24-hour medically supervised addiction treatment for adults or adolescents provided in a medically managed or medically monitored inpatient facility, as defined by the Massachusetts Department of Public Health. Acute Treatment Services provide evaluation and withdrawal management and may include biopsychological assessment, individual and group counseling, psychoeducational groups and discharge planning. |
| **3 . Allowed Amount** | |
| | The Allowed Amount is the maximum amount that we will pay for Covered Benefits minus any applicable Member Cost Sharing.<br><br>The Allowed Amount for In-Network benefits is the contracted rate the Plan has agreed to pay Plan Providers.<br><br>If services provided by a Non-Plan Provider are Covered Benefits under this Benefit Handbook, the Allowed Amount for such services depends upon where you receive the service, as explained below:<br><br>a. If you receive Out-of-Network services in the states of Massachusetts, New Hampshire, Maine, Rhode Island or Vermont, the Allowed Amount is defined as follows:<br><br>The Allowed Amount is the lower of the Provider's charge or a rate determined as described below:<br><br>An amount that is consistent, in the judgment of the Plan, with the normal range of charges by health care Providers for the same, or similar, products or services provided to a Member. If the Plan has appropriate data for the area, the Plan will determine the normal range of charges in the geographic area where the product or services were provided to the Member. If the Plan does not have data to reasonably determine the normal range of charges where the products or services were provided, the Plan will utilize the normal range of charges in Boston, Massachusetts. Where services are provided by non-physicians but the data on Provider charges available to the Plan is based on charges for services by physicians, the Plan will, in its discretion, make reasonable reductions in its determination of the allowable charge for such non-physician Providers.<br><br>b. If you receive Out-of-Network services from a Provider located outside the states of Massachusetts, New Hampshire, Maine, Rhode Island or Vermont, the Allowed Amount is defined as follows:<br><br>The Allowed Amount is the lower of the Provider's charge or a rate determined as described below:<br><br>The Allowed Amount is determined based on 150% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market.<br><br>When a rate is not published by CMS for the service, we use other industry standard methodologies to determine the Allowed Amount for the service as follows: |

| Glossary Term | Definition |
|---|---|
| **Allowed Amount (Continued)** | |
| | For services other than Pharmaceutical Products, we use a methodology called a relative value scale, which is based on the difficulty, time, work, risk and resources of the service. The relative value scale currently used is created by Optuminsight, Inc. If the Optuminsight, Inc. relative value scale becomes no longer available, a comparable scale will be used.<br><br>For Pharmaceutical Products, we use industry standard methodologies that are similar to the pricing methodology used by CMS and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.<br><br>When a rate is not published by CMS for the service and no industry standard methodology applies to the service, or the Provider does not submit sufficient information on the claim to pay it under CMS published rates or an industry standard methodology, the Allowed Amount will be 50% of the Provider's billed charge, except that the Allowed Amount for certain mental health services and substance use disorder services will be 80% of the billed charge.<br><br>Pricing of the Allowed Amount will be conducted by UnitedHealthcare, Inc. UnitedHealthcare, updates the CMS published rate data on a regular basis when updated data from CMS becomes available. These updates are typically implemented within 30 to 90 days after CMS updates its data. |
| **4 . Anniversary Date** | |
| | The date upon which the yearly premium rate is adjusted and benefit changes normally become effective. The EOC will terminate unless renewed on the Anniversary Date.<br><br>**For Example:** If your Anniversary Date is January 1st, this is the date when the Plan goes into effect and begins to pay for Covered Benefits. |
| **5 . Benefit Handbook (or Handbook)** | |
| | This document that describes the terms and conditions of the Plan, including but not limited to, Covered Benefits and exclusions from coverage. |
| **6 . Benefit Limit** | |
| | The day, visit or dollar limit maximum that applies to certain Covered Benefits, up to the Allowed Amount or Recognized Amount, if applicable. Once the Benefit Limit has been reached, no more benefits will be paid for such services or supplies. If you exceed the Benefit Limit, you are responsible for all charges incurred. The Benefit Limits applicable to your Plan are listed in your Schedule of Benefits.<br><br>**For Example:** If your Plan offers 30 visits per Plan Year or Calendar Year for physical therapy services, once you reach your 30 visit limit for that Plan Year or Calendar Year, no additional benefits for that service will be covered by the Plan. |
| **7 . Calendar Year** | |
| | The one-year period beginning on January 1 for which benefits are purchased and administered. Benefits for which limited yearly coverage is provided renew at the beginning of the Calendar Year. Benefits for which limited coverage is provided every two years renew at the beginning of every second Calendar Year. Benefits under your Plan are administered on either a Plan Year or Calendar Year basis. Please see your Schedule of Benefits to determine which type of year your Plan utilizes. |

| Glossary Term | Definition |
|---|---|
| **8 . Centers of Excellence** | |
| | Plan Providers with special training, experience, facilities or protocols for certain services, selected by us based on the findings of recognized specialty organizations or government agencies such as Medicare. Certain specialized services are only covered as In-Network services in Massachusetts, Maine, New Hampshire or Rhode Island, when received from designated Centers of Excellence. |
| **9 . Clinical Stabilization Services** | |
| | 24-hour clinically managed post detoxification treatment for adults or adolescents, as defined by the Massachusetts Department of Public Health. Clinical Stabilization Services usually follow Acute Treatment Services for substance use disorders. Clinical Stabilization Services may include intensive education and counseling regarding the nature of addiction and its consequences, relapse prevention, outreach to families and significant others and after care planning, for individuals beginning to engage in recovery from addiction. |
| **10 . Coinsurance** | |
| | A percentage of the Allowed Amount or Recognized Amount, if applicable, for certain Covered Benefits that must be paid by the Member. Coinsurance amounts are in addition to any Deductible and any applicable Copayment. Coinsurance amounts applicable to your Plan are stated in your Schedule of Benefits.<br>**For Example:** If the Coinsurance for a service is 20%, you pay 20% of the Allowed Amount while we pay the remaining 80%. (In the case of Out-of-Network services, we only pay up to the Allowed Amount, unless it is a Surprise Bill.) |
| **11 . Commonwealth Health Insurance Connector Authority or Connector** | |
| | The independent public authority created to implement portions of the Massachusetts Health Care Reform Law. The Connector is operated under the Massachusetts Executive Office for Administration and Finance. Its mission is to "connect" eligible Massachusetts residents to health care plans deemed a good value and high quality by the Connector. |
| **12 . Copayment** | |
| | A fixed dollar amount you must pay for certain Covered Benefits. The Copayment is usually due at the time services are rendered or when billed by the Provider.<br>Your specific Copayment amounts, and the services to which they apply, are listed in your Schedule of Benefits.<br>**For Example:** If your Plan has a $20 Copayment for outpatient visits, you'll pay $20 at the time of the visit or when you are billed by the Provider. |
| **13 . Cosmetic Services** | |
| | Cosmetic Services are surgery, procedures or treatments that are performed primarily to reshape or improve the individual's appearance. |
| **14 . Covered Benefit(s)** | |
| | The products and services that a Member is eligible to receive, or obtain payment for, under the Plan. |
| **15 . Custodial Care** | |
| | Services provided to a person for the primary purpose of meeting non-medical personal needs (e.g., bathing, dressing, preparing meals, including special diets, taking medication, assisting with mobility). |

| Glossary Term | Definition |
|---|---|
| **16 . Deductible** | |
| | A specific dollar amount that is payable by a Member for Covered Benefits received each Plan Year or Calendar Year before any benefits subject to the Deductible are payable by the Plan. There may be an individual Deductible and a family Deductible, and you may have different Deductibles that apply to different Covered Benefits under your Plan. If a family Deductible applies to your Plan, it will be stated in the Schedule of Benefits.<br>**For Example:** If your Plan has a $500 Deductible and you have a claim with the Allowed Amount of $1,000, you will be responsible for the first $500 to satisfy your Deductible requirement before the Plan begins to pay benefits. |
| **17 . Dental Care** | |
| | Any service provided by a licensed dentist involving the diagnosis or treatment of any disease, pain, injury, deformity or other condition of the human teeth, alveolar process, gums, jaw or associated structures of the mouth. However, surgery performed by an oral maxillofacial surgeon to correct positioning of the bones of the jaw (orthognathic surgery) is not considered Dental Care within the meaning of this definition. |
| **18 . Dependent** | |
| | A Member of the Subscriber's family who (1) meets the eligibility requirements for coverage through a Subscriber and (2) is enrolled in the Plan. |
| **19 . Enrollment Form** | |
| | A form by which the Subscriber may enroll in this Plan, on behalf of him—or herself and any covered Dependents, and under which Members agree to certain terms. |
| **20 . Evidence of Coverage (EOC)** | |
| | The legal documents, including the Benefit Handbook, Schedule of Benefits, Prescription Drug Brochure, and any applicable riders and amendments which describe the services covered by the Plan, and other terms and conditions of coverage. This document incorporates by reference an Enrollment Form. |
| **21 . Experimental, Unproven, or Investigational** | |
| | Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests, will be deemed Experimental, Unproven, or Investigational by us under this Benefit Handbook for use in the diagnosis or treatment of a particular medical condition if any of the following is true:<br>a) The product or service is not recognized in accordance with generally accepted medical standards as being safe and effective for the use in the evaluation or treatment of the condition in question. In determining whether a service has been recognized as safe or effective in accordance with generally accepted evidence-based medical standards, primary reliance will be placed upon data from published reports in authoritative medical or scientific publications that are subject to established peer review by qualified medical or scientific experts prior to publication. In the absence of any such reports, it will generally be determined a service, procedure, device or drug is not safe and effective for the use in question.<br>**Please Note:** Autologous bone marrow transplants for the treatment of breast cancer, as required by law, are not considered Experimental or Unproven when they satisfy the criteria identified by the Massachusetts Department of Public Health.<br>b) In the case of a drug, the drug has not been approved by the United States Food and Drug Administration (FDA) (this does not include off-label uses of FDA approved drugs) or if approved for lawful marketing by the FDA and reliable scientific evidence does not support that the treatment is effective |

| Glossary Term | Definition |
|---|---|
| **Experimental, Unproven, or Investigational (Continued)** | |
| | in improving health outcomes or that appropriate patient selection has not been determined.<br>c) For purposes of the treatment of infertility only, the service, procedure, drug or device has not been recognized as a "non-experimental infertility procedure" under the Massachusetts Infertility Benefit Regulations at 211 CMR Section 37.00 et. seq. |
| **22 . Family Coverage** | |
| | Coverage for a Member and one or more Dependents. |
| **23 . Flex Provider** | |
| | An outpatient Provider that provides certain Covered Benefits with lower Member Cost Sharing. When you receive certain Covered Benefits from a Flex Provider you will pay a lower Member Cost Sharing amount than if you received the same Covered Benefits from a Provider that is not a Flex Provider. If your Plan includes Flex Providers, they will be listed in your Provider Directory. For a complete list of Plan Providers, please see your Provider Directory which may be found at **www.harvardpilgrim.org**. |
| **24 . Habilitation Services** | |
| | Health care services that help a person keep, learn or improve skills and functioning for daily living. These services may include physical and occupational therapies and speech-language services. |
| **25 . Health Savings Account or HSA** | |
| | A tax-exempt trust or custodial account, similar to an individual retirement account (IRA), but established to pay qualified medical expenses. In order to establish a Health Savings Account an individual must (1) be covered under a High Deductible Health Plan during the months in which contributions are made to the account, (2) not be covered by any other health plan that is not a High Deductible Health Plan (with certain limited exceptions established by law), (3) not be entitled to Medicare benefits, and (4) not be claimed as a dependent on another person's tax return. Members should consult a qualified tax advisor before establishing a Health Savings Account. |
| **26 . High Deductible Health Plan** | |
| | A health care plan that meets the requirements of Section 223 of the Internal Revenue Code with respect to Deductibles and Out-of-Pocket Maximums. A person who is enrolled in a High Deductible Health Plan and meets other requirements stated in that law may establish a Health Savings Account (or HSA) for the purpose of paying qualified medical expenses. |
| **27 . HPHC Insurance Company, Inc. (HPHC)** | |
| | HPHC Insurance Company, Inc. is an insurance company that underwrites the health care benefits described in this Handbook. |
| **28 . Identification Card (or ID Card)** | |
| | An Identification Card will be issued by us to each Member. This card must be presented whenever a Member receives health care services. Possession of a Plan Identification Card is not a guarantee of benefits. The holder of the card must be a current Member on whose behalf the Plan has received all applicable premium payments. In addition, the health care services received must be Covered Benefits. Fraudulent use of an Identification Card may result in the immediate termination of the Member's coverage. |
| **29 . Individual Coverage** | |
| | Coverage for a Subscriber only. No coverage for Dependents is provided. |
| **30 . Individual Member** | |
| | A category of Member for which there is no employer financial contribution to the health care premiums under this Plan and under which the Subscriber is responsible for the complete cost of health care premiums for the Plan. |

| Glossary Term | Definition |
|---|---|
| **31 . In-Network** | |
| | The level of benefits or coverage a Member receives when Covered Benefits are obtained through a Plan Provider. |
| **32 . Licensed Mental Health Professional** | |
| | For services provided in Massachusetts, a Licensed Mental Health Professional is any one of the following: a licensed physician who specializes in the practice of psychiatry; a licensed psychologist; a licensed independent clinical social worker; a licensed certified social worker; a licensed mental health counselor; a licensed supervised mental health counselor; a licensed psychiatric nurse mental health clinical specialist; a licensed psychiatric mental health nurse practitioner; a licensed physician assistant who practices in the area of psychiatry; a level I licensed alcohol and drug counselor; a clinician practicing under the supervision of a licensed professional and working towards licensure in a clinic licensed under chapter 111; or a licensed marriage and family therapist. For services provided outside of Massachusetts, a Licensed Mental Health Professional is an independently licensed clinician with at least a masters degree in a clinical mental health discipline from an accredited educational institution and at least two years of clinical experience. The term "clinical mental health discipline" includes the following: psychiatry; psychology, clinical social work; marriage and family therapy; clinical counseling; developmental psychology; pastoral counseling; psychiatric nursing; developmental or educational psychology; counselor education; or any other discipline deemed acceptable by HPHC. |
| **33 . Medical Drugs** | |
| | A prescription drug that is administered to you either (1) in a doctor's office or other outpatient medical facility, or (2) at home while you are receiving home health care services or receiving drugs administered by home infusion services. Medical Drugs cannot be self-administered. The words "cannot be self-administered" mean that the active participation of skilled medical personnel is always required to take the drug. When a Member is receiving drugs in the home, the words "cannot be self-administered" will also include circumstances in which a family member or friend is trained to administer the drug and ongoing supervision by skilled medical personnel is required. |
| **34 . Medical Emergency** | |
| | A medical condition, whether physical or behavioral health (including a condition resulting from a substance use disorder), manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the Member or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part. With respect to a pregnant woman who is having contractions, Medical Emergency also means that there is inadequate time to effect a safe transfer to another hospital before delivery or that transfer may pose a threat to the health or safety of the woman or the unborn child.<br><br>Examples of Medical Emergencies are: heart attack or suspected heart attack, stroke, shock, major blood loss, choking, severe head trauma, loss of consciousness, seizures and convulsions.<br><br>Please remember that if you are hospitalized, you must call HPHC within 48 hours or as soon as you can. If the notice of hospitalization is given to HPHC by an attending emergency physician, no further notice is required. |

| Glossary Term | Definition |
|---|---|
| **35 . Medical Emergency Services** | |
| | Services provided during a Medical Emergency, including:<br>• A medical screening examination (as required under section 1867 of the Social Security Act or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a hospital, or an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Medical Emergency, and<br>• Further medical examination and treatment, within the capabilities of the staff and facilities available at the hospital or independent freestanding emergency department, as applicable, as are required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient (regardless of the department of the hospital in which such further exam or treatment is provided).<br>• Items and services, otherwise covered under the Plan, that are provided by a Non-Plan Provider or facility (regardless of the department of the hospital in which the items and services are provided) after the Member is stabilized and as part of an inpatient stay or outpatient services that are connected to the original Medical Emergency, unless each of the following conditions are met:<br>a. The Provider or facility, as described above, determines the Member is able to travel using non-medical transportation or non-emergency medical transportation.<br>b. The Provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.<br>c. The patient is in such a condition to receive information as stated in b) above and to provide informed consent in accordance with applicable law.<br>d. Any other conditions as specified by the Secretary. |
| **36 . Medically Necessary or Medical Necessity** | |
| | Those health care services that are consistent with generally accepted principles of professional medical practice as determined by whether: (a) the service is the most appropriate supply or level of service for the Member's condition, considering the potential benefit and harm to the individual; (b) the service is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; and, (c) for services and interventions that are not widely used, the use of the service for the Member's condition is based on scientific evidence.<br><br>To determine coverage of Medically Necessary services, we use Medical Necessity Guidelines (MNG) created using clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care. Members or their practitioners may obtain a copy of the Medical Necessity Guideline(s) applicable to a service or procedure for which coverage is requested by going online or calling Member Services at **1-877-907-4742**. |
| **37 . Member** | |
| | Any Subscriber or Dependent covered under the Plan. |

| Glossary Term | Definition |
|---|---|
| **38 . Member Cost Sharing** | |
| | The responsibility of Members to assume a share of the cost of the benefits provided under the Plan. Member Cost Sharing may include Copayments, Coinsurance and Deductibles. Please refer to your Schedule of Benefits for the specific Member Cost Sharing that applies to your Plan.<br>There may be two types of office visit cost sharing that apply to your Plan: a lower cost sharing known as "Level 1" and a higher cost sharing known as "Level 2." |
| **39 . Non-Plan Provider** | |
| | A Provider who does not have an agreement or contract with HPHC or its affiliates to provide care to Members. Payments for services received from Non-Plan Providers are limited to the Allowed Amount or Out-of-Network Rate, if applicable. When care is received from a Non-Plan Provider, Members are responsible for the applicable Deductible and Coinsurance plus any amounts in excess of the Allowed Amount, unless it is a Surprise Bill. The Deductible and Coinsurance amounts are described in your Schedule of Benefits. |
| **40 . Out-of-Network** | |
| | The level of benefits or coverage a Member receives when Covered Benefits are obtained through a Non-Plan Provider. |
| **41 . Out-of-Network Rate** | |
| | With respect to a Surprise Bill, the total amount paid by the Plan to a Non-Plan Provider for Covered Benefits under section 2799A-1 and 2799A-2 of the Public Service Act and their implementing regulations for: (1) Emergency Medical Services, (2) non-emergency ancillary services, (3) non-emergency, non-ancillary services, and (4) air ambulance services. The amount is based on: (1) Applicable state law, (2) an All Payer Model Agreement if adopted, (3) the initial payment made by us or the amount subsequently agreed to by the Non-Plan Provider and us, or (4) the amount determined by Independent Dispute Resolution between us and the Non-Plan Provider. |
| **42 . Out-of-Pocket Maximum** | |
| | An Out-of-Pocket Maximum is a limit on the amount of Copayments, Deductibles or Coinsurance that you must pay for Covered Benefits in a Plan Year or Calendar Year. The Out-of-Pocket Maximum is specified in your Schedule of Benefits.<br>**Please Note:** Penalty payments and charges above the Allowed Amount never apply to the Out-of-Pocket Maximum.<br>**For Example:** If your plan has an individual Out-of-Pocket Maximum of $1,000, this is the most Member Cost Sharing you will pay for out-of-pocket costs for that Plan Year or Calendar Year. As an example, the Out-of-Pocket Maximum can be reached by the following: $500 in Deductible expenses, $400 in Coinsurance expenses and $100 in Copayment expenses. |
| **43 . Penalty** | |
| | The amount that a Member is responsible to pay for certain Out-of-Network medical services or Medical Drugs when Prior Approval has not been received before receiving the services. The Penalty charge is in addition to any Member Cost Sharing amounts. Please see section *I.F. PRIOR APPROVAL* for a detailed explanation of the Prior Approval program. A Penalty amount does not apply to an Out-of-Pocket Maximum, if any. |

| Glossary Term | Definition |
|---|---|
| **44 . Physical Functional Impairment** | |
| | A condition in which the normal or proper action of a body part is damaged, and affects the ability to participate in Activities of Daily Living. Physical Functional Impairments include, but are not limited to, problems with ambulation, communication, respiration, swallowing, vision, or skin integrity.<br>A physical condition may impact an individual's emotional well-being or mental health. However such impact is not considered in determining whether or not a Physical Functional Impairment exists. Only the physical consequences of a condition are considered. |
| **45 . Plan** | |
| | This package of health care benefits offered by HPHC Insurance Company, Inc. |
| **46 . Plan Provider** | |
| | Providers who are under contract to provide In-Network services to Plan Members, and have agreed to charge Members only the applicable Copayments, Coinsurance and Deductible amounts for Covered Benefits. Plan Providers are listed in the Provider Directory. |
| **47 . Plan Year** | |
| | The one-year period for which benefits are administered. Benefits for which limited yearly coverage is provided renew at the beginning of the Plan Year. Benefits for which limited coverage is provided every two years renew at the beginning of every second Plan Year. For all Individual Member Plans, benefits are administered on Calendar Year basis and benefits will renew at the beginning of the Calendar Year on January 1. |
| **48 . Premium** | |
| | A payment made to us for health coverage under the Plan. |
| **49 . Primary Care Provider (PCP)** | |
| | A Plan Provider who provides, coordinates, or helps a Member access a range of health care services. A PCP may be a physician, nurse practitioner or a physician's assistant practicing in any of the following medical specialties: internal medicine, family practice, gynecology and reproductive health, adult medicine, pediatrics, adolescent medicine or geriatrics. |
| **50 . Prior Approval or Prior Approval Program (also known as Prior Authorization)** | |
| | A program to (1) verify that certain Covered Benefits are and continue to be, Medically Necessary and provided in an appropriate and cost-effective manner or (2) arrange for the payment of benefits.<br>Please see section *I.F. PRIOR APPROVAL* for a detailed explanation of the Prior Approval Program. |
| **51 . Provider** | |
| | A Provider is defined as: a hospital or facility that is licensed to provide inpatient medical, surgical, or rehabilitative services; a Skilled Nursing Facility; and medical professionals. Care must be provided within the lawful scope of the Provider's license. Providers include but are not limited to: physicians, psychologists, psychiatrists, podiatrists, nurse practitioners, advanced practice registered nurses, physician's assistants, psychiatric social workers, licensed nurse mental health clinical specialist, psychotherapists, psychologists, licensed independent clinical social workers, licensed mental health counselors, level I licensed alcohol and drug counselors, optometrists, physicians with recognized expertise in specialty pediatrics (including mental health and substance use disorder treatment), nurse midwives, nurse anesthetists, chiropractors, acupuncturists, optometrists, speech-language pathologists and audiologists, and early intervention specialists who are credentialed and certified by the Massachusetts Department of Public Health. Dentists may also be Providers |

| Glossary Term | Definition |
|---|---|
| **Provider (Continued)** | |
| | when providing services under this Plan. (Please note that coverage for dental services is very limited.) Plan Providers are listed in the Provider Directory. |
| **52 . Provider Directory** | |
| | A directory that identifies Plan Providers. We may revise the Provider Directory from time to time without notice to Members. The most current listing of Plan Providers is available on **www.harvardpilgrim.org**. |
| **53 . Recognized Amount** | |
| | With respect to a Surprise Bill, the amount on which a Copayment, Coinsurance or Deductible is based for Medical Emergency Services and certain non-emergency Covered Benefits when provided by Non-Plan Providers. The amount under sections 2799A-1 and 2799A-2 of the Public Service Act and their implementing regulations is based on: (1) Applicable state law, (2) an All Payer Model Agreement if adopted, or (3) the lesser of the amount billed by the Provider or the qualifying payment amount as determined under applicable law.<br><br>**Please Note:** Member Cost Sharing based on the Recognized Amount may be higher or lower than Member Cost Sharing based on the Allowed Amount. |
| **54 . Rehabilitation Services** | |
| | Rehabilitation Services are treatments for disease or injury that restore or move an individual toward functional capabilities prior to disease or injury. For treatment of congenital anomalies with significant functional impairment, Rehabilitation Services improve functional capabilities to or toward normal function for age appropriate skills. Only the following are covered: cardiac rehabilitation therapy; occupational therapy; physical therapy; pulmonary rehabilitation therapy; speech therapy; or an organized program of these services when rendered by a health care professional licensed to perform these therapies. |
| **55 . Schedule of Benefits** | |
| | A summary of the benefits covered under your Plan is listed in the Schedule of Benefits. A more detailed description of the benefits is in this Benefit Handbook. In addition, the Schedule of Benefits contains any limitations and Copayments, Coinsurance or Deductible you must pay. |
| **56 . Service Area** | |
| | The Service Area includes the states of Massachusetts, Maine, New Hampshire, Rhode Island or Vermont. |
| **57 . Skilled Nursing Facility** | |
| | An inpatient extended care facility, or part of one, that is operating pursuant to law and provides skilled nursing services. |
| **58 . Subscriber** | |
| | The person who (1) meets all applicable eligibility requirements for enrollment in the Plan, and (2) for whom the premium has been received by the Plan. |
| **59 . Surgery - Outpatient** | |
| | A surgery or procedure in a day surgery department, ambulatory surgery department or outpatient surgery center that requires operating room, anesthesia and recovery room services. |

| Glossary Term | Definition |
|---|---|
| **60 . Surprise Bill** | |
| | An unexpected bill you may receive if: (1) you obtain services from a Non-Plan Provider in an emergency, (2) you obtain services from a Non-Plan Provider while you were receiving a service from a Plan Provider or facility, and you did not knowingly select the Non-Plan Provider, (3) you obtain air ambulance services from a Non-Plan Provider, or (4) you obtain services from a Non-Plan Provider during a service previously approved or authorized by HPHC where you did not knowingly select a Non-Plan Provider. |
| **61 . Surrogacy** | |
| | Any procedure in which a person serves as the gestational carrier of a child with the goal or intention of transferring custody of the child after birth to an individual (or individuals) who is (are) unable or unwilling to serve as the gestational carrier. This includes both procedures in which the gestational carrier is, and is not, genetically related to the child. |
| **62 . Urgent Care** | |
| | Medically Necessary services for a condition that requires prompt medical attention but is not a Medical Emergency. |

# III. Covered Benefits

This section describes all of the benefits available under the Plan. Please see your Schedule of Benefits for your specific Covered Benefits.

Some benefits have limits on the amount of coverage provided in a Plan Year or Calendar Year. If a Covered Benefit has a benefit limit, your In-Network or Out-of-Network benefits are combined and count toward your benefit limit. For example, if the Covered Benefit is limited to ten visits per Plan Year or Calendar Year and you receive nine visits In-Network and one visit Out-of-Network, then you have reached your benefit limit. That benefit will not be covered again until the next Plan Year or Calendar Year.

Member Cost Sharing information and any applicable benefit limitations that apply to your Plan are listed in your Schedule of Benefits. Benefits are administered on a Plan Year or Calendar Year basis.

The Plan does not impose any restrictions, limitations or exclusions related to preexisting conditions on your Covered Benefits.

**Basic Requirements for Coverage**

To be covered, all services and supplies must meet each of the following requirements. They must be:

- Listed as a Covered Benefit in this section.
- Medically Necessary.
- Not excluded in section *IV. Exclusions*.
- Received while an active Member of the Plan.
- In-Network services must be provided by a Plan Provider. The only exception is care needed in a Medical Emergency.
- Some services require Prior Approval by the Plan. Please see section *I.F. PRIOR APPROVAL* for information on the Prior Approval Program.
- In Massachusetts, Maine, New Hampshire and Rhode Island there are certain specialized services that must be received from designated Plan Providers, referred to as "Centers of Excellence," to receive In-Network benefits. Please see section *I.D.5. Centers of Excellence* for a list of these services.

| Benefit | Description |
|---|---|
| **63 . Acupuncture Treatment** | |
| | The Plan covers acupuncture treatment for, including, electro-acupuncture, that is provided for the treatment of neuromusculoskeletal pain. |
| **64 . Ambulance and Medical Transport** | |
| | **Emergency Ambulance Transport**<br><br>If you have a Medical Emergency (including an emergency related to a substance use disorder or mental health condition), your Plan covers ambulance transport (ground and air) to the nearest hospital that can provide you with Medically Necessary care.<br><br>**Non-Emergency Medical Transport**<br><br>You're also covered for non-emergency medical transport, including but not limited to ambulance and wheelchair vans, between hospitals or other covered health care facilities or from a covered facility to your home when Medically Necessary. Services must be arranged by a Provider.<br><br>**Prior Approval Required:** You must obtain Prior Approval for non-emergency medical transportation. Please note Prior Approval is not required for transportation provided by a wheelchair van. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior |

| Benefit | Description |
|---|---|
| **Ambulance and Medical Transport (Continued)** | |
| | Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information. |
| **65 . Autism Spectrum Disorders Treatment** | |
| | Coverage is provided for the diagnosis and treatment of Autism Spectrum Disorders, as defined below. Covered Benefits include the following:<br>• Diagnosis of Autism Spectrum Disorders. This includes Medically Necessary assessments, evaluations, including neuropsychological evaluations, genetic testing or other tests to diagnose whether an individual has one of the Autism Spectrum Disorders.<br>• Professional services by Providers. This includes care by physicians, Licensed Mental Health Professionals, speech therapists, occupational therapists, and physical therapists.<br>• Rehabilitation and Habilitation Services, including but not limited to, applied behavior analysis supervised by a board certified behavior analyst as defined by law.<br>• Prescription drug coverage. Please see your Prescription Drug Brochure for information on this benefit.<br>Autism Spectrum Disorders include any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders. These include Autistic Disorder; Asperger's Disorder; and Pervasive Developmental Disorders Not Otherwise Specified.<br>Applied behavior analysis is defined by Massachusetts law as the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior. It includes the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.<br>There is no coverage for services provided under an individualized education program (IEP), including any services provided under an IEP that are delivered by school personnel or any services provided under an IEP purchased from a contractor or vendor.<br>**Prior Approval Required:** You must obtain Prior Approval for Applied Behavioral Analysis (ABA) services. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information. |
| **66 . Bariatric Surgery** | |
| | The Plan covers the surgical treatment of obesity and morbid obesity (bariatric surgery). Services are covered in accordance with the patient qualification and treatment standards set forth by the American Society for Metabolic and Bariatric Surgery or the American College of Surgeons. Coverage may be limited or excluded under your Plan unless services are performed at a designated Center of Excellence. Please see section *I.D.5. Centers of Excellence* for important information concerning your coverage for this service.<br>**Important Notice:** We use clinical guidelines to evaluate whether bariatric surgery is Medically Necessary. If you are planning to receive bariatric surgery services we recommend that you review the Medical Necessity Guidelines. To obtain a copy, please call Member Services at **1-877-907-4742**. |

| Benefit | Description |
|---|---|
| **67 . Cardiac Rehabilitation Therapy** | |
| | The Plan covers cardiac rehabilitation as required by Massachusetts law. Coverage includes only Medically Necessary services for Members with established coronary artery disease or unusual and serious risk factors for such disease. |
| **68 . Chemotherapy and Radiation Therapy** | |
| | The Plan covers outpatient chemotherapy administration and radiation therapy at a hospital or other outpatient medical facility. Covered Benefits include the facility charge, the charge for related supplies and equipment, and physician services for anesthesiologists, pathologists and radiologists.<br><br>**Prior Approval Required:** You must obtain Prior Approval for radiation oncology. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information. |
| **69 . Clinical Trials for the Treatment of Cancer or Other Life-Threatening Diseases** | |
| | The Plan covers services for Members enrolled in a qualified clinical trial of a treatment for any form of cancer or other life-threatening disease under the terms and conditions provided for under Massachusetts and federal law. All of the requirements for coverage under the Plan apply to coverage under this benefit. The following services are covered under this benefit: (1) all services that are Medically Necessary for treatment of your condition, consistent with the study protocol of the clinical trial, and for which coverage is otherwise available under the Plan; and (2) the reasonable cost of an investigational drug or device that has been approved for use in the clinical trial to the extent it is not paid for by its manufacturer, distributor or Provider. |
| **70 . COVID-19 Services** | |
| | The Plan covers vaccines, testing and treatment for COVID-19 as required by Massachusetts law. Vaccines are covered in full with no Member Cost Sharing. Testing and treatment are covered with no Member Cost Sharing after the Deductible has been met and without the use of Prior Approval processes when Medically Necessary and provided by either Plan or Non-Plan Providers.<br><br>The following services are covered:<br><br>• **COVID-19 Vaccines**<br>• **COVID-19 Testing** – COVID-19 polymerase chain reaction (PCR) and antigen tests for symptomatic individuals, individuals identified as close contacts by state or local health officials, and asymptomatic individuals under circumstances in accordance with Massachusetts law. Antibody tests are covered when Medically Necessary in order to support treatment for COVID-19, or for a Member whose immune system is compromised and/or knowledge of COVID-19 antibodies may impact the future outcome of treatment. COVID-19 testing solely intended for return to work, school, or other locations is not Medically Necessary and accordingly not covered.<br>• **COVID-19 Treatment** – COVID-19-related treatment for all emergency, inpatient services, outpatient services, and cognitive rehabilitation services, including all related professional, diagnostic, and laboratory services, as required by Massachusetts law. Please note, Member Cost Sharing may apply to covered services related to treatment of reactions to the COVID-19 vaccine. |

| Benefit | Description |
|---|---|
| **71 . Dental Services** | |
| | **Important Notice:** The Plan does not provide dental insurance. It covers only the limited Dental Care described below. No other Dental Care is covered.<br><br>**Cleft Palate:**<br><br>For coverage of orthodontic and dental care related to the treatment of cleft lip or cleft palate for children up to the age of 18, please see section *III. Covered Benefits*, *Reconstructive Surgery,* for information on this benefit.<br><br>**Emergency Dental Care:**<br><br>The Plan covers emergency Dental Care needed due to an injury to sound, natural teeth. All services, except for suture removal, must be received within three days of injury. Only the following services are covered:<br>• Extraction of the teeth damaged in the injury when needed to avoid infection<br>• Reimplantation and stabilization of dislodged teeth<br>• Repositioning and stabilization of partly dislodged teeth<br>• Suturing and suture removal<br>• Medication received from the Provider<br><br>**Extraction of Teeth Impacted in Bone:**<br><br>The Plan covers extraction of teeth impacted in bone. Only the following services are covered:<br>• Extraction of teeth impacted in bone<br>• Pre-operative and post-operative care, immediately following the procedure<br>• Anesthesia<br>• Bitewing x-rays<br>**Prior Approval Required:** You must obtain Prior Approval for treatment of cleft palate and the extraction of teeth impacted in bone. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information.<br><br>**Please Note:** Your Plan may provide coverage for pediatric dental services. Please see your Schedule of Benefits and any associated riders to determine if your Plan provides coverage for this benefit. |

| Benefit | Description |
|---|---|
| **72 . Diabetes Services and Supplies** | |
| | **Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care:**<br><br>The Plan covers outpatient self-management education and training for the treatment of diabetes, including medical nutrition therapy services, used to diagnose or treat insulin-dependent diabetes, non-insulin dependent diabetes, or gestational diabetes. Services must be provided on an individual basis. Benefits also include medical eye exams (dilated retinal exams) and preventive foot care. Diabetes equipment and supplies are also covered. Some equipment and supplies listed below may be furnished by a Durable Medical Equipment (DME) provider or a pharmacy. Your Member Cost Sharing is based on who furnishes the equipment and/or supplies.<br>The following items are covered:<br><br>**Diabetes Equipment (covered under your DME benefit):**<br><br>• Blood glucose monitors<br>• Continuous glucose monitors<br>• Dosage gauges<br>• Injectors<br>• Insulin pumps (including supplies) and infusion devices<br>• Lancet devices<br>• Therapeutic molded shoes and inserts<br>• Visual magnifying aids<br>• Voice synthesizers<br>Please see the "Durable Medical Equipment (DME): benefit for more information.<br><br>**Pharmacy Supplies (covered at a pharmacy):**<br><br>• Certain blood glucose monitors<br>• Certain insulin pumps (including supplies) and infusion devices<br>• Blood glucose strips<br>• Flash glucose monitors (including supplies)<br>• Insulin, insulin needles and syringes<br>• Lancets<br>• Oral agents for controlling blood sugar<br>• Urine and ketone test strips<br>For coverage of pharmacy items listed above, you must get a prescription from your Provider and present it at a participating pharmacy. You can find participating pharmacies by logging into **your secure online account** at **www.harvardpilgrim.org** or by calling Member Services at **1-877-907-4742**.<br>Please see the "Drug Coverage" benefit for more information.<br>**Prior Approval Required:** You must obtain Prior Approval for certain diabetic equipment and supplies. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information. |

| Benefit | Description |
|---|---|
| **73 . Dialysis** | |
| | The Plan covers dialysis on an inpatient, outpatient or at home basis. When federal law permits Medicare to be the primary payer, you must apply for Medicare and also pay any Medicare premium. When Medicare is primary (or would be primary if the Member were timely enrolled) under federal law, the Plan will cover only those costs that exceed what would be payable by Medicare.<br><br>Coverage for dialysis in the home includes non-durable medical supplies, and drugs and equipment necessary for dialysis.<br><br>**Prior Approval Required:** You must obtain Prior Approval for any planned inpatient admission or for any service provided in the home. If you use a Plan Provider located within the Service Area, he or she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information. |
| **74 . Drug Coverage** | |
| | **1) Drug Coverage under this Benefit Handbook**<br><br>a. Medical Drugs Received During Outpatient or Home Care. A Medical Drug is administered to you either (1) in a doctor's office or other outpatient medical facility, or (2) at home while you are receiving home care services or receiving drugs administered by home infusion services.<br><br>Medical Drugs cannot be self-administered. The words "cannot be self-administered" mean that the active participation of skilled medical personnel is always required to take the drug. When a Member is receiving drugs in the home, the words "cannot be self-administered" will also include circumstances in which a family member or friend is trained to administer the drug and ongoing supervision by skilled medical personnel is required.<br><br>An example of a drug that cannot be self-administered is a drug that must be administered intravenously. Examples of drugs that can be self-administered are drugs that can be taken in pill form and drugs that are typically self-injected by the patient.<br><br>See your Schedule of Benefits for your Medical Drug Member Cost Sharing.<br>b. Drugs and supplies required by law:<br><br>Some drugs or supplies required by law may only be available through a pharmacy. Coverage is provided for:<br><br>• certain diabetes supplies. See the "Diabetes Services and Supplies" benefit for details.<br><br>• syringes and needles you purchase at a pharmacy. See the "Hypodermic Syringes and Needles" benefit for details.<br><br>• certain prescribed self-administered anticancer medications used to kill or slow the growth of cancerous cells are covered with no Member Cost Sharing after the Deductible has been met.<br><br>• long-term antibiotic therapy for a Member diagnosed with Lyme disease as required by law. Please note: the plan will provide coverage for a long-term antibiotic drug, including an experimental drug, for an off-label use in the treatment of Lyme disease if the drug has been approved by the United States Food and Drug Administration.<br><br>No coverage is provided under this Benefit Handbook for (1) drugs that have not been approved by the United States Food and Drug Administration; (2) drugs the Plan excludes or limits, including, but not limited to, drugs for cosmetic purposes; and (3) any drug that is obtained at an outpatient pharmacy except as explained above. |

| Benefit | Description |
|---|---|
| **Drug Coverage (Continued)** | |
| | **Prior Approval Required:** You must obtain Prior Approval for select Medical Drugs. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-877-907-4742**. Please see section *I.F. PRIOR APPROVAL* for more information.<br><br>**2) Outpatient Prescription Drug Coverage**<br><br>In addition to the coverage provided under this Benefit Handbook, you also have HPHC's outpatient prescription drug rider. That rider covers most prescription drugs purchased at an outpatient pharmacy.<br>See the Prescription Drug Brochure for more information. See your ID card for your Member Cost Sharing. |
| **75 . Durable Medical Equipment (DME)** | |
| | The Plan covers DME when Medically Necessary and ordered by a Provider. We will rent or buy all equipment. The cost of the repair and maintenance of covered equipment is also covered.<br>In order to be covered, all equipment must be:<br>• Able to withstand repeated use;<br>• Not generally useful in the absence of disease or injury;<br>• Normally used in the treatment of an illness or injury or for the rehabilitation of an abnormal body part; and<br>• Suitable for home use.<br>Coverage is only available for:<br>• The least costly equipment adequate to allow you to perform Activities of Daily Living. Activities of Daily Living do not include special functions needed for occupational purposes or sports; and<br>• One item of each type of equipment. No back-up items or items that serve a duplicate purpose are covered. For example, the Plan covers a manual or an electric wheelchair, not both.<br>Covered equipment and supplies include:<br>• Canes<br>• Certain diabetes supplies and equipment (See the "Diabetes Services and Supplies" benefit for details.<br>• Certain types of braces<br>• Crutches<br>• Hospital beds<br>• Oxygen and oxygen equipment<br>• Respiratory equipment<br>• Walkers<br>• Wheelchairs<br>Member Cost Sharing amounts you are required to pay are based on the cost of equipment to the Plan.<br>**Prior Approval Required:** You must obtain Prior Approval for positive airway pressure devices, including CPAP and BIPAP devices and power wheelchairs. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information. |

| Benefit | Description |
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| **76 . Early Intervention Services** | |
| | The Plan covers early intervention services provided for Members until three years of age. Covered Benefits include:<br>• Nursing care<br>• Physical, speech, and occupational therapy<br>• Psychological counseling<br>• Screening and assessment of the need for services |
| **77 . Emergency Room Care** | |
| | If you have a Medical Emergency, you are covered for care in a hospital emergency room. Please remember the following:<br>• If you need follow-up care after you are treated in an emergency room, you must get your care from a Plan Provider for coverage to be at the In-Network benefit payment level.<br>• If you are hospitalized, you must call the Plan at **1-877-907-4742** within 48 hours or as soon as you can. This telephone number can also be found on your ID card. If notice of hospitalization is given to the Plan by an attending emergency physician no further notice is required |
| **78 . Family Planning Services** | |
| | The Plan covers family planning services, including the following:<br>• Contraceptive monitoring<br>• Family planning consultation<br>• Pregnancy testing<br>• Genetic counseling<br>• FDA approved birth control drugs, implants or devices.<br>• Professional services relating to the injection of birth control drugs and the insertion or removal of birth control implants or devices. |
| **79 . Fertility Services** | |
| | This fertility benefit applies to members who do not meet the definition of infertility under Massachusetts law (M.G.L. c. 175, section 47H and 211 C.M.R 37.09). This benefit is meant to support inclusive family expansion for people across sexual orientation and gender identity spectra, including those without coparenting partners. Fertility services may be considered Medically Necessary without a diagnosis of infertility.<br>The Plan covers fertility services when determined to be Medically Necessary. Only the following fertility services are covered:<br>• **Intra-cytoplasmic sperm injection (ICSI)**<br>• **Intrauterine Insemination (IUI)**<br>• **Donor sperm**<br>• **Donor egg** procedures, including related egg and inseminated egg procurement, processing and cryopreservation up to a maximum of 24 months.<br>• **In-Vitro Fertilization (IVF)**<br>• **Reciprocal In-Vitro Fertilization (IVF)**<br>Please Note: No coverage is provided for reciprocal IVF services for non-Members.<br>• **Laboratory testing**, including blood testing, sperm testing, and ultrasound related to the covered fertility services listed above. |

| Benefit | Description |
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| **Fertility Services (Continued)** | |
| | • **Preimplantation genetic testing (PGT)**<br>Please see section, Infertility Services and Treatment for information on other services related to Assistive Reproductive Technology procedures covered under the Plan.<br><br>**Important Notice:** We use evidence based clinical criteria to evaluate whether the use of fertility service is Medically Necessary. If you are planning to receive fertility services we recommend that you review the current Medical Necessity Guidelines online at **www.harvardpilgrim.org**. To obtain a copy, call Member Services at **1-877-907-4742**.<br><br>**Prior Approval Required:** You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information. |
| **80 . Gender Affirming Services** | |
| | The Plan covers gender affirming services to the extent Medically Necessary and in accordance with clinical guidelines. HPHC consults up-to-date medical standards set forth by nationally recognized medical experts in the transgender field, including but not limited to those issued by the World Professional Association for Transgender Health (WPATH), to develop clinical guidelines and determine Medical Necessity. When a Member meets Medical Necessity Guidelines, coverage includes:<br><br>• Surgery<br>• Related physician and behavioral health visits<br>• outpatient prescription drugs<br><br>Procedures required in preparation for, as a component of, as a follow-up to, or as a revision to a covered treatment are also covered.<br><br>**Important Notice:** We use clinical criteria/guidelines to evaluate whether gender affirming services are Medically Necessary. If you are planning to receive gender affirming services, you should review the current Medical Necessity Guidelines that identify covered services under this benefit. To obtain a copy, please call Member Services at **1-877-907-4742** or go to our website at **www.harvardpilgrim.org**.<br><br>Benefits for gender affirming services are in addition to other benefits provided under the Plan. HPHC does not consider gender affirming services to be reconstructive surgery to correct a Physical Functional Impairment or Cosmetic Services. Coverage for reconstructive surgery or Cosmetic Services is limited to the services described under the Reconstructive Surgery benefit in this Benefit Handbook.<br><br>**Prior Approval Required:** You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information. |

| Benefit | Description |
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| **81 . Hearing Aids** | |
| | The Plan covers hearing aids up to the limit listed in your Schedule of Benefits. A hearing aid is defined as any instrument or device, excluding a surgical implant, designed, intended or offered for the purpose of improving a person's hearing.<br>The Plan will pay the full cost of each medically necessary hearing aid up to the limit listed in your Schedule of Benefits, minus any applicable Member Cost Sharing. If you purchase a hearing aid that is more expensive than the limit listed in your Schedule of Benefits, you will be responsible for the additional cost. No back-up hearing aids that serve a duplicate purpose are covered. Covered services and supplies related to your hearing aid are not subject to the dollar limit listed in your Schedule of Benefits.<br>Covered Benefits include the following:<br>• One hearing aid per hearing impaired ear<br>• Except for batteries, any necessary parts, attachments or accessories, including ear moldings; and<br>• Services provided by a licensed audiologist, hearing instrument specialist or licensed physician that are necessary to assess, select, fit, adjust or service the hearing aid.<br>**Prior Approval Required:** You must obtain Prior Approval for cochlear implants. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information. |
| **82 . Home Health Care** | |
| | If you are homebound for medical reasons, you are covered for home health care services listed below. To be eligible for home health care, your Provider must determine that skilled nursing care or physical therapy is an essential part of active treatment. There must also be a defined medical goal that your Provider expects you will meet.<br>When you qualify for home health care services as stated above, the Plan covers the following services when Medically Necessary:<br>• Durable medical equipment and supplies (must be a component of the home health care being provided)<br>• Medical and surgical supplies<br>• Medical social services<br>• Nutritional counseling<br>• Physical therapy<br>• Occupational therapy<br>• Palliative care<br>• Services of a home health aide<br>• Skilled nursing care<br>• Speech therapy<br>**Prior Approval Required:** You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see the section *I.F. PRIOR APPROVAL* for more information. |

| Benefit | Description |
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| **83 . Hospice Services** | |
| | The Plan covers hospice services for terminally ill Members who need the skills of qualified technical or professional health personnel for palliative care. Care may be provided at home or on an inpatient basis. Inpatient respite care is covered for the purpose of relieving the primary caregiver and may be provided up to 5 days every 3 months not to exceed 14 days per Plan Year or Calendar Year. Inpatient care is also covered in an acute hospital or extended care facility when it is Medically Necessary to control pain and manage acute and severe clinical problems that cannot be managed in a home setting. Covered Benefits include:<br>• Care to relieve pain<br>• Counseling<br>• Drugs that cannot be self-administered<br>• Durable medical equipment appliances<br>• Home health aide services<br>• Medical supplies<br>• Nursing care<br>• Physician services<br>• Occupational therapy<br>• Physical therapy<br>• Speech therapy<br>• Respiratory therapy<br>• Respite care<br>• Social services<br>**Prior Approval Required:** You must obtain Prior Approval for hospice care. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information. |
| **84 . Hospital – Inpatient Services** | |
| | The Plan covers acute hospital care including, but not limited to, the following inpatient services:<br>• Semi-private room and board<br>• Doctor visits, including consultation with specialists<br>• Palliative care<br>• Medications<br>• Laboratory, radiology and other diagnostic services<br>• Intensive care<br>• Surgery, including related services<br>• Anesthesia, including the services of a nurse-anesthetist<br>• Radiation therapy<br>• Physical therapy<br>• Occupational therapy<br>• Speech therapy<br>**Please Note:** In Massachusetts, Maine, New Hampshire and Rhode Island there are certain specialized services that must be received from designated |

| Benefit | Description |
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| **Hospital – Inpatient Services (Continued)** | |
| | Plan Providers, referred to as "Centers of Excellence" to receive In-Network coverage. Please see section *I.D.5. Centers of Excellence* for further information.<br><br>**Prior Approval Required:** You must obtain Prior Approval for any planned inpatient admission. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information. |
| **85 . House Calls** | |
| | The Plan covers house calls. |
| **86 . Human Organ Transplant Services** | |
| | The Plan covers human organ transplants, including bone marrow transplants for a Member with metastasized breast cancer in accordance with the criteria of the Massachusetts Department of Public Health.<br><br>The Plan covers the following services when the recipient is a Member of the Plan:<br><br>• Care for the recipient<br>• Donor search costs through established organ donor registries<br>• Donor costs that are not covered by the donor's health plan<br><br>If a Member is a donor for a recipient who is not a Member, then the Plan will cover the donor costs for the Member, when they are not covered by the recipient's health plan.<br><br>**Prior Approval Required:** You must obtain Prior Approval for any planned inpatient admission. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information. |
| **87 . Hypodermic Syringes and Needles** | |
| | The Plan covers hypodermic syringes and needles to the extent Medically Necessary, as required by Massachusetts law.<br><br>You must get a prescription from your Provider and present it at a participating pharmacy for coverage. You can get more information on participating pharmacies by logging into **your secure online account** at **www.harvardpilgrim.org** or by calling Member Services at **1-877-907-4742.** |
| **88 . Infertility Services and Treatment** | |
| | Infertility is defined as the inability of a woman aged 35 or younger to conceive or produce conception during a period of one year. In the case of a woman over age 35, the time period is reduced to 6 months. If a woman conceives but is unable to carry the pregnancy to live birth, the time she attempted to conceive prior to that pregnancy is included in the one year or 6 month period, as applicable. The Plan covers the following diagnostic services for infertility:<br><br>• Consultation<br>• Evaluation<br>• Laboratory tests<br>• Preimplantation genetic testing (PGT)<br><br>When the Member meets Medical Necessity Guidelines, the Plan covers the following infertility treatment:<br><br>• Therapeutic artificial insemination (AI), including related sperm procurement and banking |

| Benefit | Description |
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| **Infertility Services and Treatment (Continued)** | |
| | • Donor egg procedures, including related egg and inseminated egg procurement, processing and banking<br>• Donor oocyte (DO/IVF)<br>• Donor embryo/frozen embryo transfer (DO/FET)<br>• Frozen embryo transfer (FET)<br>• Assisted hatching<br>• Gamete intrafallopian transfer (GIFT)<br>• Intra-cytoplasmic sperm injection (ICSI)<br>• Intra-uterine insemination (IUI)<br>• In-vitro fertilization and embryo transfer (IVF)<br>• Zygote intrafallopian transfer (ZIFT)<br>• Miscrosurgical epididiymal sperm aspiration (MESA)<br>• Testicular sperm extraction (TESE)<br>• Sperm collection, freezing and up to one year of storage is also covered for male Members in active infertility treatment.<br>• Cryopreservation of eggs, sperm, and embryos.<br><br>**Important Notice:** We use evidence based clinical criteria to evaluate whether the use of infertility treatment is Medically Necessary. Infertility treatments evolve and new treatments may be developed. If you are planning to receive infertility treatment we recommend that you review the current Medical Necessity Guidelines online at **www.harvardpilgrim.org**. To obtain a copy, call Member Services at **1-877-907-4742**.<br><br>**Prior Approval Required:** You must obtain Prior Approval for all services for the treatment of infertility. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information. |
| **89 . Laboratory, Radiology and Other Diagnostic Services** | |
| | The Plan covers laboratory and radiology services (including Advanced Radiology), and other diagnostic services on an outpatient basis. The term "Advanced Radiology" means CT scans, PET Scans, MRI and MRA, and nuclear medicine services. Coverage includes:<br><br>• The facility charge and the charge for supplies and equipment.<br>• The charges of anesthesiologists, pathologists and radiologists.<br><br>In addition, the Plan covers the following:<br><br>• Human leukocyte antigen testing or histocompatibility locus antigen testing necessary to establish bone marrow transplant donor suitability (including testing for A, B, or DR antigens, or any combination, consistent with rules, regulations and criteria established by the Department of Public Health).<br>• Diagnostic screenings and tests as required by law including: hereditary and metabolic screening at birth; tuberculin tests; lead screenings; hematocrit, hemoglobin or other appropriate blood tests, human leukocyte antigen testing or histocompatibility locus antigen testing necessary to establish bone marrow transplant donor suitability, and urinalysis.<br>• Screening and diagnostic mammograms. |

| Benefit | Description |
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| **Laboratory, Radiology and Other Diagnostic Services (Continued)** | |
| | **Prior Approval Required:** You must obtain Prior Approval for computerized axial tomography (CAT and CT and CTA scans); Magnetic resonance imaging (MRI and MRA scans); Nuclear cardiac studies; and Positron emission tomography (PET scans). If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information. |
| **90 . Low Protein Foods** | |
| | The Plan covers food products modified to be low-protein ordered for the treatment of inherited diseases of amino acids and organic acids to the extent required by Massachusetts law. |
| **91 . Maternity Care** | |
| | The Plan covers the following maternity services:<br>• Routine outpatient prenatal care, including evaluation and progress screening, physical exams, recording of weight and blood pressure monitoring<br>• Prenatal genetic testing<br>• Delivery, including a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a caesarean section. Any decision to shorten the inpatient stay for the mother and her newborn child will be made by the attending physician and the mother. If early discharge is decided, the mother will be entitled to a minimum of one home visit.<br>• Newborn care. Coverage is limited to routine nursery charges for a healthy newborn unless the child is enrolled in the Plan.<br>• Routine outpatient postpartum care for the mother, up to six weeks after delivery.<br>The plan will reimburse you up to the Benefit Limit stated in your Schedule of Benefits for fees paid for one childbirth course (or refresher course) for each pregnancy. Members are expected to attend childbirth classes recommended by their physician, nurse midwife or health care facility. You will receive reimbursement for the course following completion unless delivery occurs before the course ends.<br>To request reimbursement, you will need to complete a reimbursement form and provide the Plan with proof of payment. Please submit your documents along with the reimbursement form to the following address:<br>**Harvard Pilgrim Health Care**<br>**P.O. Box 9185**<br>**Quincy, MA 02269**<br>To obtain a reimbursement form, please contact Member Services at **1-877-907-4742** or visit HPHC online at **www.harvardpilgrim.org**.<br>**Prior Approval Required:** You must obtain Prior Approval for any planned inpatient admission or when a newborn is admitted to a neonatal intensive care unit. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information. |

| Benefit | Description |
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| **92 . Medical Formulas** | |
| | The Plan covers the following to the extent required by Massachusetts law:<br>• Non-prescription enteral formulas for home use for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction and inherited diseases of amino acids and organic acids.<br>• Prescription formulas for the treatment of phenylketonuria, tyrosinemia, homocystrinuria, maple syrup urine disease, propionic acidemia or methylmalonic acidemia in infants and children or to protect the unborn fetuses of pregnant women with phenylketonuria.<br>**Prior Approval Required:** You must obtain Prior Approval for outpatient formulas and enteral nutrition. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information. |
| **93 . Mental Health and Substance Use Disorder Treatment** | |
| | The Plan covers both inpatient and outpatient mental health and substance use disorder treatment to the extent Medically Necessary as outlined below.<br>In a Medical Emergency you should go to the nearest emergency facility or call 911 or your local emergency number. If you are admitted to the hospital, you must call the Plan at **1-877-907-4742** within 48 hours or as soon as you can. This telephone number is also on your ID card. If an attending emergency physician contacts us or your PCP, then no further notice is needed. See the *Glossary* for additional information on Medical Emergency Services.<br>The Plan requires consent to the disclosure of information regarding services for mental disorders to the same extent it requires consent for disclosure of information for other medical conditions. Any determination of Medical Necessity for mental health care will be made in consultation with a Licensed Mental Health Professional.<br>**Minimum Requirements for Covered Providers**<br>To be eligible for coverage under this benefit, all services must be provided either (1) at the office of a Licensed Mental Health Professional, or (2) at a facility licensed or approved by the health department or mental health department of the state in which the service is provided. (In Massachusetts those departments are the Department of Public Health and the Department of Mental Health, respectively.) To qualify, a facility must be both licensed as, and function primarily as, a health or mental health and substance use disorder treatment facility. A facility that is also licensed as an educational or recreational institution will not meet this requirement unless the predominate purpose of the facility is the provision of mental health and substance use disorder treatment. In addition to numbers (1) and (2) above, services to treat child-adolescent mental health disorders may be provided in the least restrictive clinically appropriate setting. This may include the Member's home or a program in another community-based setting. Please see below for additional information on services to treat child-adolescent mental health disorders.<br>To qualify for coverage, all services rendered outside of a state licensed or approved facility must be provided by an independently Licensed Mental Health Professional. If a Provider of intermediate care or outpatient services to treat child-adolescent mental health disorders is not independently licensed at the Masters/PhD/MD level, then the supervisor – who must be a Masters Level independently Licensed Mental Health Professional – must sign off on the treatment plan whenever the child's or adolescent's condition changes. |

| Benefit | Description |
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| **Mental Health and Substance Use Disorder Treatment (Continued)** | |
| | For services provided in Massachusetts, a Licensed Mental Health Professional must be one of the following types of Providers: a licensed physician who specializes in the practice of psychiatry; a licensed psychologist; a licensed independent clinical social worker; a licensed certified social worker; a licensed mental health counselor; a licensed supervised mental health counselor; a licensed psychiatric nurse mental health clinical specialist; a licensed psychiatric mental health nurse practitioner; a licensed physician assistant who practices in the area of psychiatry; a level I licensed alcohol and drug counselor; a clinician practicing under the supervision of a licensed professional and working towards licensure in a clinic licensed under chapter 111; or a licensed marriage and family therapist. For services provided outside of Massachusetts, a Licensed Mental Health Professional is an independently licensed clinician with at least a Masters degree in a clinical mental health discipline from an accredited educational institution and at least two years of clinical experience. The term "clinical mental health discipline" includes the following: psychiatry; psychology; clinical social work; marriage and family therapy; clinical counseling; developmental psychology; pastoral counseling; psychiatric nursing; developmental or educational psychology; counselor education; or any other discipline deemed acceptable by the Plan.<br><br>**Coverage for Massachusetts Parity Conditions including Child-Adolescent Mental Health Disorders**<br><br>Under Massachusetts law, services for three categories of conditions must be covered to the same extent as medical services for physical illnesses. These three categories are (1) services for "biologically-based mental disorders," (2) services required as a result of rape, and (3) services for child-adolescent mental health disorders. Further information on the coverage provided for these conditions can be found below.<br>1) **Services Required to Treat Biologically-Based Mental Disorders**<br>The Plan covers services required to treat biologically based mental disorders. Biologically-based mental disorders are (1) schizophrenia, (2) schizoaffective disorders, (3) major depressive disorder, (4) bipolar disorder, (5) paranoia and other psychotic disorders, (6) obsessive-compulsive disorder, (7) panic disorder, (8) delirium and dementia, (9) affective disorders, (10) eating disorders, (11) post-traumatic stress disorders, (12) substance use disorders, and (13) autism.<br>2) **Services Required as a Result of Rape**<br>The Plan covers services required to diagnose and treat rape-related mental or emotional disorders for victims of rape or victims of an assault with the attempt to commit rape.<br>3) **Services for Child-Adolescent Mental Health Disorders**<br>The Plan covers services on a non-discriminatory basis for the diagnosis and treatment of child-adolescent mental health disorders that substantially interfere with or substantially limit the functioning and social interactions of a child or adolescent through the age of 18. Substantial interference with, or limitation of, function must be documented by the Member's physician, primary pediatrician or HPHC Licensed Mental Health Professional, or when evidenced by conduct including, but not limited to:<br>• the inability to attend school as a result of the disorder,<br>• the need for hospitalization as a result of the disorder, or<br>• a pattern of conduct or behavior caused by the disorder that poses a serious danger to self or others. |

| Benefit | Description |
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| **Mental Health and Substance Use Disorder Treatment (Continued)** | |
| | Child-adolescent mental health services shall take place in the least restrictive clinically appropriate setting and shall consist of a range of inpatient, intermediate, and outpatient services that shall permit Medically Necessary, active care expected to lead to improvement of the condition in a reasonable period of time. The covered services may be provided to the child, the child's parent(s), and/or other appropriate caregivers.<br><br>Coverage under this subsection shall continue after the child's 19th birthday until either the course of treatment specified in the child's treatment plan is completed or coverage under this Handbook is terminated, whichever comes first. If treatment of a 19 year old, as specified in his or her treatment plan, has not been completed at the time coverage under this Handbook is terminated, such treatment may be continued under a replacement plan issued by HPHC.<br><br>**Medically Necessary Emergency Services Programs**<br><br>Under Massachusetts law, coverage is provided for Medically Necessary Emergency Services Programs. The term "Emergency Services Programs" is defined as all programs subject to contract between the Massachusetts Behavioral Health Partnership (MBHP) and nonprofit organizations for the provisions of community-based emergency psychiatric services, including but not limited to, behavioral health crisis assessment, intervention and stabilization services 24 hours per day, 7 days per week, through: (i) mobile crisis intervention services for youth: (ii) mobile crisis intervention services for adults; (iii) emergency services provider community-based locations; and (iv) adult community crisis stabilization services.<br><br>In Massachusetts, designated Community Based Health Centers (CBHCs) serve as regional hubs of coordinated and integrated mental health and substance use disorder treatment and provide routine and urgent outpatient services, crisis services for adults and youth, and community crisis stabilization services for adults and youth. CBHCs will also provide community-based Mobile Crisis Intervention (MCI) for both youths and adults.<br><br>**Coverage for Other Conditions**<br><br>In addition to the coverage discussed above, the Plan will provide coverage for the care of all other conditions listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders. Services for all other conditions not identified above will be covered to the extent Medically Necessary.<br><br>**Mental Health and Substance Use Disorder Treatment**<br><br>Subject to the Member Cost Sharing and any benefit limits stated in your Schedule of Benefits, the Plan provides coverage for the following Medically Necessary mental health and substance use disorder treatment:<br>1) **Inpatient Services**<br>• Hospitalization, including detoxification<br>2) **Intermediate Care Services**<br>• Acute residential treatment (including detoxification)<br>• Intensive Outpatient Programs (IOPs) and Partial Hospitalization Programs (PHPs)<br>• Mobile Crisis Intervention (MCI) |

| Benefit | Description |
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| **Mental Health and Substance Use Disorder Treatment (Continued)** | |
| | • Adult Mobile Crisis Intervention (AMCI) – provides a course of treatment intended to promote recovery, ensure safety, and stabilize the crisis. For individuals who do not require inpatient services or another 24-hour level of care, AMCI provides up to three days of daily post-stabilization follow-up care.<br>• Youth Mobile Crisis Intervention (YMCI) - provides crisis assessment and crisis stabilization intervention to youth under the age of 21. Each YMCI encounter, including ongoing coordination following the crisis assessment and stabilization intervention, may last up to seven days.<br>3) **Intermediate Care Services for children and adolescents**<br>• Intensive community-based acute treatment (ICBAT) – intensive therapeutic services provided in a staff-secure setting on a 24-hour basis, with sufficient staffing to ensure safety, while providing intensive therapeutic services including but not limited to: daily medication monitoring; psychiatric assessment; nursing availability; specialing (as needed); individual group and family therapy; case management; family assessment and consultation; discharge planning; and psychological testing, as needed. This service may be used as an alternative to or transition from inpatient services.<br>• Community-based acute treatment (CBAT) – provides the same services as CBAT but at a higher intensity, including more frequent psychiatric and psychopharmacological evaluation and treatment and more intensive staffing and service delivery. ICBAT programs have the capability to admit children and adolescents with more acute symptoms than those admitted to CBAT. ICBAT programs are able to treat Children and adolescents with clinical presentations similar to those referred to inpatient mental health services but who are able to be cared for safely in an unlocked setting. Children and adolescents may be admitted to an ICBAT directly from the community as an alternative to inpatient hospitalization. ICBAT is not used as a step-down placement following discharge from a locked, 24-hour setting.<br>4) **Outpatient Services**<br>• Annual mental health wellness examination performed by a Licensed Mental Health Professional or by a PCP during a routine physical exam. A mental health wellness examination is a screening or assessment that seeks to identify any behavioral or mental health needs and appropriate resources for treatment.<br>• Care by a Licensed Mental Health Professional (including online counseling through secure digital messaging)<br>• Crisis intervention services<br>• Crisis stabilization and in-home family stabilization<br>• Detoxification<br>• Medication management<br>• Methadone maintenance<br>• Psychological testing and neuropsychological assessment.<br>5) **Outpatient Services for children and adolescents**<br>• Treatment for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric |

| Benefit | Description |
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| **Mental Health and Substance Use Disorder Treatment (Continued)** | |
| | acute-onset neuropsychiatric syndrome (PANS) including, but not limited to, the use of intravenous immunoglobulin therapy (IVIG).<br>• Intensive care coordination (ICC) – a collaborative service that provides targeted case management services to children and adolescents with a serious emotional disturbance, including individuals with co-occurring conditions, in order to meet the comprehensive medical, behavioral health, and psychosocial needs of an individual and the individual's family, while promoting quality, cost effective outcomes. This service includes an assessment, the development of an individualized care plan, referrals to appropriate levels of care, monitoring of goals, and coordinating with other services and social supports and with state agencies, as indicated. The service shall be based upon a system of care philosophy and the individualized care plan shall be tailored to meet the needs of the individual. The service is delivered in office, home or other settings and shall include both face-to-face and telephonic meetings, as indicated and as clinically appropriate.<br>• In-home behavioral services (IHBS) - a combination of behavior management therapy and behavior management monitoring. Services shall be available, when indicated, where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting. In-home behavioral services include:<br>  • *Behavior management monitoring* of a child's behavior, the implementations of a behavior plan and reinforcing implementation of a behavior plan by the child's parent or other care giver.<br>  • *Behavioral management therapy* that addresses challenging behaviors that interfere with a child's successful functioning. That therapy shall include a functional behavioral assessment and observation of the youth in the home and/or community setting, development of a behavior plan, and supervision and coordination of interventions to address specific behavioral objectives or performance, including the development of a crisis-response strategy and may include short-term counseling and assistance.<br>• In-home therapy (IHT) - therapeutic clinical intervention or ongoing therapeutic training and support. The intervention or support shall be provided where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting.<br>  • *Therapeutic clinical intervention* shall include: (i) a structured and consistent therapeutic relationship between a licensed clinician and a child and the child's family to treat the child's mental health needs, including improvement of the family's ability to provide effective support for the child and promotion of healthy functioning of the child within the family; (ii) the development of a treatment plan; and (iii) the use of established psychotherapeutic techniques, working with the family or a subset of the family to enhance problem solving, limit setting, communication, emotional support or other family or individual functions.<br>  • *Ongoing therapeutic training and support* of a treatment plan pursuant to therapeutic clinical intervention that includes but is not limited to, teaching the child to understand, direct, interpret, manage and control feelings and emotional responses to situation and assisting the family in supporting the child and addressing the child's emotional and mental health needs. |

| Benefit | Description |
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| **Mental Health and Substance Use Disorder Treatment (Continued)** | |
| | • Family support and training (FS&T) – services provided to a parent or other caregiver of a child to improve the capacity of the parent or caregiver to ameliorate or resolve the child's emotional or behavioral needs. Such services shall be provided where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting. Family support and training addresses one or more goals on the youth's behavioral health treatment plan and may include educating parents/caregivers about the youth's behavioral health needs and resiliency factors, teaching parents/caregivers how to navigate services on behalf of the child and how to identify formal and informal services and supports in their communities, including parent support and self-help groups.<br>• Therapeutic monitoring (TM) services – services provided to a child designed to support age-appropriate social functioning or to ameliorate deficits in the child's age-appropriate social functioning resulting from a DSM diagnosis. Services may include supporting, coaching, and training the child in age-appropriate behaviors, interpersonal communication, problem solving, conflict resolution, and relating appropriately to other children and adolescents and to adults. Services shall be provided, when indicated, where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting. Therapeutic mentoring is a skill building service addressing one or more goals on the youth's behavioral treatment plan. It may also be delivered in the community to allow the youth to practice desired skills in appropriate settings.<br>Please refer to your Schedule of Benefits for the Member Cost Sharing amounts that apply to your "inpatient," "intermediate" and "outpatient" mental health and substance abuse disorder treatment services.<br>**Prior Approval Required:** You must obtain Prior Approval for the following services:<br>• **In-home behavioral services (IHBS)**<br>• **In-home therapy (IHT)**<br>• **Psychological and neuropsychological testing**<br>• **Applied Behavioral Analysis (ABA) services for the treatment of Autism**<br>• **Repetitive Transcranial Magnetic Stimulation (rTMS)**<br>If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information.<br>**Please Note:** Prior Approval is not required for the first 14 days of Medically Necessary Acute Treatment Services or Clinical Stabilization Services from either a Plan Provider or a Non-Plan Provider. The terms "Acute Treatment Services" and "Clinical Stabilization Services" are defined in the Glossary at Section II of this Benefit Handbook. Services beyond the 14 day period may be subject to concurrent review as described in section *XI.L. UTILIZATION REVIEW PROCEDURES* of this Handbook. |

| Benefit | Description |
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| **94 . Observation Services** | |
| | The Plan covers observation services including short term treatment, assessment and reassessment for up to 48 hours in an acute care facility (i.e. hospital). Observation services determine if a Member needs to be admitted for additional treatment or if the Member is able to be discharged from the hospital. |
| **95 . Ostomy Supplies** | |
| | The Plan covers ostomy supplies up to the Benefit Limit listed in the Schedule of Benefits. Only the following supplies are covered:<br>• Irrigation sleeves, bags and catheters<br>• Pouches, face plates and belts<br>• Skin barriers |
| **96 . Palliative Care** | |
| | The Plan covers palliative care in conjunction with inpatient, home health care, hospice and physician services. Member Cost Sharing for palliative care is included in the cost sharing associated with these services.<br>Palliative care is a medical specialty that supports improved quality of life for Members with chronic or serious illness. Care is focused on providing relief from symptoms and the stress of illness. Palliative care can be provided at any stage of illness, along with treatment for your condition while remaining under the care of your regular Provider. This care is offered alongside curative or other treatments you may be receiving.<br>Palliative care may include physician services, nursing care, home health care, pain and symptom management, medication management, rehabilitation therapies (occupational, physical, speech and pulmonary), behavioral health services and durable medical equipment. |
| **97 . Physician and Other Professional Office Visits** | |
| | Physician services, including services of all covered medical professionals, can be obtained on an outpatient basis in a physician's office or a hospital. These services may include:<br>• Routine physical examinations, including routine gynecological examination and annual cytological screenings<br>• Follow-up care provided by an obstetrician or gynecologist for obstetrical or gynecological conditions identified during maternity care or annual gynecological visit<br>• Psychiatric collaborative care in which a primary care team provides structured behavioral health care management to a Member. A primary care team includes a PCP and a care manager working in collaboration with a psychiatric consultant that provides regular consultations to the team to review the Member's clinical status and care and to make recommendations. **Please Note:** Not all PCP offices provide this service.<br>• Immunizations, including childhood immunizations as recommended by the United States Department of Health and Human Services, Centers for Disease Control and Prevention and the American Academy of Pediatrics<br>• Well baby and well child care, including physical examination, history, measurements, sensory screening, neuropsychiatric evaluation and developmental screening, and assessment at the following intervals:<br>  • At least six visits per Plan Year or Calendar Year are covered for a child from birth to age one. |

| Benefit | Description |
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| **Physician and Other Professional Office Visits (Continued)** | |
| | • At least three visits per Plan Year or Calendar Year are covered for a child from age one to age two.<br>• At least one visit per Plan Year or Calendar Year is covered for a child from age two to age six.<br>• School, camp, sports and premarital examinations<br>• Health education and nutritional counseling<br>• Palliative care<br>• Sickness and injury care<br>• Vision and Hearing screenings<br>• Medication management<br>• Consultations concerning contraception and hormone replacement therapy<br>• Chemotherapy<br>• Radiation therapy<br>**Please Note:** Your Plan covers certain preventive services and tests with no Member Cost Sharing. Please see your Schedule of Benefits for the coverage that applies to your Plan. |
| **98 . Prosthetic Devices** | |
| | The Plan covers prosthetic devices when ordered by a Provider. The cost of the repair and maintenance of a covered device is also covered.<br>In order to be covered, all devices must be able to withstand repeated use.<br>Coverage is only available for:<br>• The least costly prosthetic device adequate to allow you to perform Activities of Daily Living. Activities of Daily Living do not include special functions needed for occupational purposes or sports; and<br>• One item of each type of prosthetic device. No back-up items or items that serve a duplicate purpose are covered.<br>Covered prostheses include:<br>• Breast prostheses, including replacements and mastectomy bras<br>• Prosthetic arms and legs (including myoelectric and bionic arms and legs)<br>• Prosthetic eyes<br>Member Cost Sharing amounts you are required to pay are based on the cost of equipment to the Plan.<br>**Prior Approval Required:** You must obtain Prior Approval for prosthetic arms and legs. If you use a Plan Provider located within the Service Area, he or she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information. |

| Benefit | Description |
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| **99 . Reconstructive Surgery** | |
| | The Plan covers reconstructive and restorative surgical procedures as follows:<br>• Reconstructive surgery is covered when the surgery can reasonably be expected to improve or correct a Physical Functional Impairment resulting from an accidental injury, illness, congenital anomaly, birth injury or prior surgical procedure. If reconstructive surgery is performed to improve or correct a Physical Functional Impairment, as stated above, Cosmetic Services that are incidental to that surgery are also covered. After a Physical Functional Impairment is corrected, no further Cosmetic Services are covered by the Plan.<br>• Restorative surgery is covered to repair or restore appearance damaged by an accidental injury. (For example, this benefit would cover repair of a facial deformity following an automobile accident.)<br>Benefits are also provided for the following:<br>• Post mastectomy care, including coverage for:<br>– Prostheses and physical complications for all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient;<br>– Reconstruction of the breast on which the mastectomy was performed; and<br>– Surgery and reconstruction of the other breast to produce a symmetrical appearance.<br>• Treatment of cleft lip and cleft palate for children up to the age of 18, including coverage for:<br>– Medical, dental, oral, and facial surgery, including surgery performed by oral and plastic surgeons, and surgical management and follow-up care related to such surgery;<br>– Orthodontic treatment;<br>– Preventative and restorative dentistry to ensure good health and adequate dental structures to support orthodontic treatment or prosthetic management therapy;<br>– Speech therapy;<br>– Audiology services; and<br>– Nutrition services.<br>• Treatment to correct or repair disturbances of body composition caused by HIV-associated lipodystrophy syndrome, including but not limited to coverage for:<br>– Reconstructive surgery;<br>– Restorative procedures; and<br>– Dermal injections or fillers to treat facial lipoatrophy associated with HIV.<br>Benefits include coverage for procedures that must be done in stages, as long as you are an active Member. Membership must be effective on all dates on which services are provided.<br>There is no coverage for Cosmetic Services or surgery except for (1) Cosmetic Services that are incidental to the correction of a Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury, (3) post-mastectomy care as described above, and (4) gender affirming procedures and related services. |

| Benefit | Description |
|---|---|
| **Reconstructive Surgery (Continued)** | |
| | **Important Notice:** We use clinical guidelines to evaluate whether different types of reconstructive and restorative procedures are Medically Necessary. If you are planning to receive such treatment, you may review the current Medical Necessity Guidelines online at **www.harvardpilgrim.org**. To obtain a copy, call Member Services at **1-877-907-4742**.<br><br>**Prior Approval Required:** You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information. |
| **100 . Rehabilitation Hospital Care** | |
| | The Plan covers care in a facility licensed to provide rehabilitative care on an inpatient basis. Coverage is provided when you need daily Rehabilitation Services that must be provided in an inpatient setting. Rehabilitation Services include cardiac rehabilitation therapy, physical therapy, pulmonary rehabilitation therapy, occupational therapy and speech therapy. The Benefit Limit is listed in the Schedule of Benefits.<br><br>**Prior Approval Required:** You must obtain Prior Approval for rehabilitation hospital care. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval Process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information. |
| **101 . Rehabilitation and Habilitation Services – Outpatient** | |
| | The Plan covers the following outpatient Rehabilitation and Habilitation Services:<br><br>• Occupational therapy<br>• Physical therapy<br>• Pulmonary rehabilitation therapy<br><br>Outpatient Rehabilitation and Habilitation Services are covered up to the Benefit Limit listed in the Schedule of Benefits. Services are covered only:<br><br>• If, in the opinion of your Provider, there is likely to be significant improvement in your condition within the period of time benefits are covered; and<br>• When needed to improve your ability to perform Activities of Daily Living.<br><br>Activities of Daily Living do not include special functions needed for occupational purposes or sports.<br><br>Rehabilitation and Habilitation Services are also covered under your inpatient hospital and home health benefits.<br><br>**Prior Approval Required:** You must obtain Prior Approval for coverage of outpatient pulmonary rehabilitation therapy. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information.<br><br>**Please Note:** Outpatient physical and occupational therapies for children up to the age of 3 are covered to the extent Medically Necessary. The benefit limit stated in the Schedule of Benefits does not apply. |

| Benefit | Description |
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| **102 . Scopic Procedures – Outpatient Diagnostic** | |
| | The Plan covers diagnostic scopic procedures and related services received on an outpatient basis.<br>Diagnostic scopic procedures are those for visualization, biopsy and/or polyp removal. Scopic procedures are:<br>• Colonoscopy<br>• Endoscopy<br>• Sigmoidoscopy |
| **103 . Skilled Nursing Facility Care** | |
| | The Plan covers care in a health care facility licensed to provide skilled nursing care on an inpatient basis. Coverage is provided only when you need daily skilled nursing care that must be provided in an inpatient setting. The Benefit Limit is listed in the Schedule of Benefits.<br>**Prior Approval Required:** You must obtain Prior Approval for Skilled Nursing Facility care. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. If you use a Plan Provider, he/she will seek Prior Approval for you. Please see section *I.F. PRIOR APPROVAL* for more information. |
| **104 . Speech-Language and Hearing Services** | |
| | The Plan covers diagnosis and treatment of speech, hearing and language disorders to the extent Medically Necessary by speech-language pathologists and audiologists. |
| **105 . Spinal Manipulative Therapy (including care by a chiropractor)** | |
| | The Plan covers musculoskeletal adjustment or manipulation up to the Benefit Limit listed in the Schedule of Benefits. |
| **106 . Surgery - Outpatient** | |
| | The Plan covers outpatient surgery, including related services. Outpatient surgery is defined as any surgery or procedure in a day surgery department, ambulatory surgery department or outpatient surgery center.<br>In Massachusetts, Maine, New Hampshire and Rhode Island there are certain specialized services that must be received from designated Plan Providers, referred to as "Center of Excellence" to receive In-Network coverage. Please see section *I.D.5. Centers of Excellence* for further information.<br>**Prior Approval Required:** You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information. |
| **107 . Telemedicine Virtual Visit Services** | |
| | The Plan covers Medically Necessary telemedicine virtual visit services for the purpose of evaluation, diagnosis, consultation, monitoring, or treatment of a Member's physical health, oral health, mental health or substance use disorder condition. Telemedicine virtual visit services include the use of synchronous or asynchronous audio, video, electronic media or other telecommunications technology including: (a) interactive audio video technology; (b) remote patient monitoring devices; (c) audio-only telephone; (d) online adaptive interviews; and (e) telemonitoring. Your Provider must be appropriately licensed in the state in which you are located when receiving telemedicine services.<br>Member Cost Sharing for telemedicine virtual visit services will be the same or less than the Member Cost Sharing for the same type of service if it had been provided through an in-person consultation. Please refer to your Schedule |

| Benefit | Description |
|---|---|
| **Telemedicine Virtual Visit Services (Continued)** | |
| | of Benefits for specific information on Member Cost Sharing you may be required to pay. |
| **108 . Temporomandibular Joint Dysfunction Services** | |
| | The Plan covers medical treatment of Temporomandibular Joint Dysfunction (TMD). Only the following services are covered:<br>• Consultation with a physician<br>• Physical therapy, (subject to the visit limit for outpatient physical therapy listed in the Schedule of Benefits)<br>• Surgery<br>• X-rays<br>**Important Notice:** No Dental Care is covered for the treatment of Temporomandibular Joint Dysfunction (TMD).<br>**Prior Approval Required:** You must obtain Prior Approval for surgery under this benefit. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information. |
| **109 . Urgent Care Services** | |
| | The Plan covers Urgent Care services you receive at (1) a convenience care clinic, (2) an urgent care center, including mobile urgent care providers, or (3) a hospital urgent care center.<br>(1) **Convenience care clinics:** Convenience care clinics provide treatment for minor illnesses and injuries. They are usually staffed by non-physician providers, such as nurse practitioners, and are located in stores, supermarkets or pharmacies. To see a list of convenience care clinics covered by the Plan, please refer to your Provider Directory and search under "convenience care."<br>(2) **Urgent care centers:** Urgent care centers provide treatment for illnesses and injuries that require urgent attention but are not life threatening. Urgent care centers are independently owned and operated centers that are considered standalone facilities, not departments of a hospital. They are staffed by doctors, nurse practitioners, and physician assistants. To see a list of urgent care centers covered by the Plan, please refer to your Provider Directory and search under "urgent care."<br>**Please Note:** You may be eligible to receive mobile urgent care services in your home, at work or anywhere you require Urgent Care. Availability of mobile urgent care services will depend upon your location. Member Cost Sharing for mobile urgent care services will be the same as if the service was provided at an urgent care center. Please refer to your Schedule of Benefits for the specific Member Cost Sharing that applies to urgent care center services under your Plan. You can call Member Services at **1-877-907-4742** or go to, **www.harvardpilgrim.org** to see where these services are available.<br>(3) **Hospital urgent care centers:** Some hospitals provide treatment for urgent care services as part of the hospital's outpatient services. A hospital urgent care center may be located within a hospital, or at a satellite location separate from the hospital. These urgent care centers are owned and operated by the hospital and are considered a department of the hospital. They are staffed by doctors, nurse practitioners, and physician assistants and provide treatment for illnesses and injuries that require urgent attention but are not life threatening. Because the services provided are considered outpatient hospital services, only the hospitals are listed in the Provider Directory. These |

| Benefit | Description |
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| **Urgent Care Services (Continued)** | |
| | services may require higher Member Cost Sharing than urgent care services received at independent urgent care centers.<br><br>**Please Note:** Hospital urgent care center services are treated differently than similar services received in a hospital emergency room. For information on services received in a hospital emergency room, please see the Emergency Room Care benefit above, and in your Schedule of Benefits.<br><br>Please refer to your Schedule of Benefits for the Member Cost Sharing applicable to each type of Urgent Care service.<br><br>Coverage for Urgent Care is provided for services that are required to prevent deterioration to your health resulting from an unforeseen sickness or injury. Covered Benefits include but are not limited to the following:<br><br>• Care for minor cuts, burns, rashes or abrasions, including suturing<br>• Treatment for minor illnesses and infections, including earaches<br>• Treatment for minor sprains or strains<br><br>Whenever possible, you should contact your PCP prior to obtaining Urgent Care. Your PCP may be able to provide the services you require at a lower out-of-pocket cost.<br><br>**Important Notice:** Urgent Care is not emergency care. You should call 911 or go directly to a hospital emergency room if you suspect you are having a Medical Emergency. These include heart attack or suspected heart attack, shock, major blood loss, or loss of consciousness. Please see section *I.D.8. Medical Emergency Services* for more information. |
| **110 . Vision Services** | |
| | **Routine Eye:**<br><br>The Plan covers routine eye examinations.<br><br>**Vision Hardware for Special Conditions:**<br><br>The Plan provides coverage for contact lenses or eyeglasses needed for the following conditions:<br><br>• Keratoconus. One pair of contact lenses is covered per Plan Year or Calendar Year. The replacement of lenses, due to a change in the Member's condition, is limited to 3 per affected eye per Plan Year or Calendar Year.<br>• Post cataract surgery with an intraocular lens implant (pseudophakes). Coverage is limited to $140 per surgery toward the purchase of eyeglass frames and lenses. The replacement of lenses due to a change in the Member's prescription of .50 diopters or more within 90 days of the surgery is also covered up to a limit of $140.<br>• Post cataract surgery without lens implant (aphakes). One pair of eyeglass lenses or contact lenses is covered per Plan Year or Calendar Year. Coverage up to $50 per Plan Year or Calendar Year is also provided for the purchase of eyeglass frames. The replacement of lenses due to a change in the Member's condition is also covered. Replacement of lenses due to wear, damage, or loss, is limited to 3 per affected eye per Plan Year or Calendar Year.<br>• Post retinal detachment surgery. For a Member who wore eyeglasses or contact lenses prior to retinal detachment surgery, the Plan covers the full cost of one lens per affected eye up to one Plan Year or Calendar Year after the date of surgery. For Members who have not previously worn eyeglasses |

| Benefit | Description |
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| **Vision Services (Continued)** | |
| | or contact lenses, the Plan covers either (1) a pair of eyeglass lenses and up to $50 toward the purchase of the frames, or (2) pair of contact lenses. |
| **111 . Voluntary Sterilization** | |
| | The Plan covers voluntary sterilization, including tubal ligation and vasectomy. |
| **112 . Voluntary Termination of Pregnancy** | |
| | The Plan covers voluntary termination of pregnancy and the following related services provided in conjunction with the covered termination procedure: 1) pre-pregnancy termination evaluation and examination; 2) pre-operative counseling; 3) ultrasounds; 4) laboratory services, including pregnancy testing, blood type, and Rh factor; 5) Rh (D) immune globulin (human); 6) anesthesia (general or local); 7) post-pregnancy termination care; 8) follow-up care; and 9) advice on contraception or referral to family planning services.<br>Care related to a pregnancy or miscarriage is not covered under this benefit. |
| **113 . Wellness Reimbursement Benefits** | |
| | As a Member of the Plan you may be able to receive reimbursement for certain fees that you pay when participating in fitness or weight management programs. Below is a description of those benefits.<br><br>**Fitness**<br><br>The Plan will reimburse you for monthly fees paid for an individual or family membership at a qualified fitness facility up to the Benefit Limit stated in your Schedule of Benefits.<br><br>To be eligible for coverage, you must have (1) been enrolled as a Member of Harvard Pilgrim, and (2) belonged to the qualified fitness facility for at least four months during the calendar year for which reimbursement is sought.<br><br>A qualified fitness facility is either (1) a facility providing cardiovascular and strength-training equipment for exercising and improving physical fitness, including private health clubs and fitness centers, YMCA's, YWCA's, Jewish Community Centers, municipal fitness centers; or (2) a studio, facility, or virtual platform with certified instructors providing yoga, pilates, Zumba, group aerobic classes, cycling or spinning classes, kickboxing, CrossFit, strength training, tennis, indoor rock climbing or personal training. No reimbursement is provided for initiation or termination fees.<br><br>The fitness benefit does not apply to any fees or costs that you pay for classes, lessons or training provided outside of a qualified fitness facility as described above. Facilities and services that are not covered include: country clubs, private tennis clubs, social clubs (such as ski, riding or hiking clubs), gymnastics facilities, pool-only facilities, sports teams or leagues, spas, instructional dance studios, martial arts schools, home gyms, or personal training sessions.<br><br>**Weight Management Program**<br><br>The Plan will reimburse you up to the Benefit Limit stated in your Schedule of Benefits for monthly fees paid for WW (Weight Watchers) digital, traditional meetings or Weight Watchers at Work programs.<br><br>No coverage is provided for individual nutritional counseling sessions, pre-packaged meals, books, videos, scales or other items or supplies bought by the Member or any other items not included as part of a weight management class or weight management course.<br><br>To request reimbursement for your fitness or weight management program, you will need to complete a reimbursement form and provide the Plan with |

| Benefit | Description |
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| **Wellness Reimbursement Benefits (Continued)** | |
| | proof of membership and proof of payment. Please submit your documents along with the reimbursement form to the following address:<br>**Harvard Pilgrim Health Care**<br>**P.O. Box 9185**<br>**Quincy, MA 02269**<br>To obtain a reimbursement form, please contact Member Servicescustomer service at **1-877-907-4742** or visit HPHC online at **www.harvardpilgrim.org**.<br>You also have the option to request reimbursement online. If you have **your secure online account**, you can complete an online reimbursement form and submit your documents online. For details on how to register for **your secure online account**, log on to **www.harvardpilgrim.org.** |
| **114 . Wigs and Scalp Hair Prostheses** | |
| | The Plan covers wigs and scalp hair prostheses when needed for hair loss suffered as a result of the treatment for any form of cancer or leukemia or for a certain pathologic condition such as alopecia areata, alopecia totalis, alopecia medicamentosa or permanent loss of scalp hair due to injury up to the Benefit Limit listed in the Schedule of Benefits. |

# IV. Exclusions

The exclusions headings in this section are intended to group together services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath the headings. A heading does not create, define, modify, limit or expand an exclusion.

**The services listed in the table below are not covered by the Plan:**

| Exclusion | Description |
|---|---|
| **1 . Alternative Treatments** | |
| | 1. Acupuncture services that are outside the scope of standard acupuncture care.<br>2. Alternative, holistic or naturopathic services and all procedures, laboratories and nutritional supplements associated with such treatments except when specifically listed as a Covered Benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for these benefits.<br>Aromatherapy, treatment with crystals and alternative medicine.<br>3. Any of the following types of programs: Health resorts, spas, recreational programs, camps, outdoor skills programs, educational programs for children in residential care, self-help programs, life skills programs, therapeutic or educational boarding schools, relaxation or lifestyle programs, and wilderness programs (therapeutic outdoor programs).<br>4. Massage therapy.<br>5. Myotherapy. |
| **2 . Dental Services** | |
| | 1. Dental Care, except the specific dental services listed as Covered Benefits in this Benefit Handbook, your Schedule of Benefits and any associated riders.<br>2. Temporomandibular Joint Dysfunction (TMD) care, except for the specific medical treatments listed as Covered Benefits in this Benefit Handbook.<br>3. Extraction of teeth, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits and any associated riders).<br>4. Pediatric dental care, except when specifically listed as a Covered Benefit. Please see your Schedule of Benefits and any associated riders to determine if your Plan provides coverage for this benefit. |
| **3 . Durable Medical Equipment and Prosthetic Devices** | |
| | 1. Any devices or special equipment needed for sports or occupational purposes.<br>2. Any home adaptations, including, but not limited to home improvements and home adaptation equipment.<br>3. Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services.<br>4. Repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft. |
| **4 . Experimental, Unproven, or Investigational Services** | |
| | 1. Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational. |

| Exclusion | Description |
|---|---|
| **5 . Foot Care** | |
| | 1. Foot orthotics, except for the treatment of severe diabetic foot disease or systemic circulatory disease.<br>2. Routine foot care. Examples include nail trimming, cutting or debriding and the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Members diagnosed with diabetes or systemic circulatory disease. |
| **6 . Maternity Services** | |
| | 1. Planned home births.<br>2. Services provided by a doula. |
| **7 . Mental Health and Substance Use Disorder Treatment** | |
| | 1. Biofeedback.<br>2. Educational services or testing, except services covered under the benefit for Early Intervention Services. No benefits are provided (1) for educational services intended to enhance educational achievement or developmental functioning, (2) to resolve problems of school performance, (3) for driver alcohol education, or (4) for community reinforcement approach and assertive continuing care.<br>3. Any of the following types of programs: programs in which the patient has a pre-defined duration of care without the Plan's ability to conduct concurrent determinations of continued medical necessity, programs that only provide meetings or activities not based on individualized treatment plans, programs that focus solely on interpersonal or other skills rather than directed toward symptom reduction and functional recovery related to specific mental health disorders, and tuition based programs that offer educational, vocational, recreational, or personal developmental activities.<br>4. Sensory integrative praxis tests.<br>5. Mental health and substance use disorder treatment that is (1) provided to Members who are confined or committed to a jail, house of correction, prison, or custodial facility of the Department of Youth Services; or (2) provided by the Department of Mental Health.<br>6. Services or supplies for the diagnosis or treatment of mental health and substance use disorders that, in the reasonable judgment of the Plan, are any of the following:<br>• Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.<br>• Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.<br>• Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective. |

| Exclusion | Description |
|---|---|
| **8 . Physical Appearance** | |
| | 1. Cosmetic Services, including drugs, devices, treatments and procedures, except for (1) Cosmetic Services that are incidental to the correction of a Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury, (3) post-mastectomy care, and (4) gender affirming procedures and related services.<br>2. Electrolysis or laser hair removal, except for what is Medically Necessary as part of gender affirming services.<br>3. Hair removal or restoration, including, but not limited to transplantation or drug therapy.<br>4. Liposuction, except for what is Medically Necessary as part of gender affirming services, or removal of fat deposits considered undesirable.<br>5. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).<br>6. Skin abrasion procedures performed as a treatment for acne.<br>7. Treatments and procedures related to appearance including but not limited to, abdominoplasty; chemical peels; collagen injections; dermabrasion; implantations (e.g. cheek, calf, pectoral, gluteal); lip reduction/enhancement; panniculectomy; removal of redundant skin; and silicone injections (e.g. for breast enlargement), except for what is Medically Necessary as part of gender affirming services or another Covered Benefit.<br>8. Treatment for skin wrinkles and skin tags or any treatment to improve the appearance of the skin.<br>9. Treatment for spider veins.<br>10. Wigs and scalp hair prostheses when hair loss is due to male pattern baldness, female pattern baldness, or natural or premature aging. |
| **9 . Procedures and Treatments** | |
| | 1. Care by a chiropractor outside the scope of standard chiropractic practice, including but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice, or treatment of infections and diagnostic testing for chiropractic care other than an initial x-ray.<br>2. Commercial diet plans, weight loss programs and any services in connection with such plans or programs, except as provided in this Benefit Handbook under Wellness Reimbursement Benefits.<br>3. If a service received in Massachusetts, Maine, New Hampshire or Rhode Island is listed as requiring that it be provided at a Center of Excellence, no In-Network coverage will be provided under this Handbook if that service is received in Massachusetts, Maine, New Hampshire or Rhode Island from a Provider that has not been designated as a Center of Excellence. Please see section *I.D.5. Centers of Excellence* for more information.<br>4. Nutritional or cosmetic therapy using vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).<br>5. Physical examinations and testing for insurance, licensing or employment.<br>6. Services for Members who are donors for non-Members, except as described under Human Organ Transplant Services. |

| Exclusion | Description |
|---|---|
| **Procedures and Treatments (Continued)** | |
| | 7. Testing for central auditory processing.<br>8. Group diabetes training, educational programs or camps. |
| **10 . Providers** | |
| | 1. Charges for services which were provided after the date on which your membership ends.<br>2. Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs, and hospital or other facility charges, that are related to any care that is not a Covered Benefit under this Handbook.<br>3. Charges for missed appointments.<br>4. Concierge service fees. (See section *I.I. PROVIDER FEES FOR SPECIAL SERVICES (CONCIERGE SERVICES)* for more information.)<br>5. Inpatient charges after your hospital discharge.<br>6. Provider's charge to file a claim or to transcribe or copy your medical records.<br>7. Services or supplies provided by (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you. |
| **11 . Reproduction** | |
| | 1. Any form of Surrogacy or services for a gestational carrier other than covered maternity services.<br>2. Infertility drugs if a Member is not in a Plan authorized cycle of infertility treatment.<br>3. Infertility drugs, if infertility services are not a Covered Benefit.<br>4. Infertility treatment for Members who are not medically infertile.<br>5. Intrauterine Insemination (IUI) services provided in the home.<br>6. Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal).<br>7. Sperm collection, freezing and storage except as described in the section *III. Covered Benefits*, *Infertility Services and Treatment*.<br>8. Sperm identification when not Medically Necessary (e.g., gender identification).<br>9. The following fees: wait list fees, non-medical costs, shipping and handling charges etc. |
| **12 . Services Provided Under Another Plan** | |
| | 1. Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities.<br>2. Costs for services for which payment is required to be made by a Workers' Compensation plan or an employer under state or federal law. |
| **13 . Telemedicine Services** | |
| | 1. Telemedicine services involving e-mail or fax.<br>2. Provider fees for technical costs for the provision of telemedicine services. |

| Exclusion | Description |
|---|---|
| **14 . Types of Care** | |
| | 1. Custodial Care.<br>2. Recovery programs including rest or domiciliary care, sober houses, transitional support services, and therapeutic communities.<br>3. All institutional charges over the semi-private room rate, except when a private room is Medically Necessary.<br>4. Pain management programs or clinics.<br>5. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation, except as provided in this Benefit Handbook under Wellness Reimbursement Benefits.<br>6. Private duty nursing.<br>7. Sports medicine clinics.<br>8. Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation. |
| **15 . Vision and Hearing** | |
| | 1. Eyeglasses, contact lenses and fittings, except as listed in this Benefit Handbook.<br>2. Hearing aid batteries, and any device used by individuals with hearing impairment to communicate over the telephone or internet, such as TTY or TDD.<br>3. Over the counter hearing aids<br>4. Refractive eye surgery, including, but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of naturally occurring myopia, hyperopia and astigmatism.<br>5. Routine eye examinations, except when specifically listed as a Covered Benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit. |
| **16 . All Other Exclusions** | |
| | 1. Any service or supply furnished in connection with a non-Covered Benefit.<br>2. Any service or supply (with the exception of contact lenses) purchased from the internet.<br>3. Any service, supply or medication when there is a less intensive Covered Benefit or more cost-effective alternative that can be safely an effectively provided, in accordance with applicable Medical Necessity Guidelines.<br>4. Any service, supply or medication that is required by a third party that is not otherwise Medically Necessary (examples of a third party are an employer, an insurance company, a school or court).<br>5. Beauty or barber service.<br>6. Diabetes equipment replacements when solely due to manufacturer warranty expiration.<br>7. Donated or banked breast milk.<br>8. Externally powered exoskeleton assistive devices and orthoses.<br>9. Food or nutritional supplements, including, but not limited to, FDA-approved medical foods obtained by prescription, except as required |

| Exclusion | Description |
|---|---|
| **All Other Exclusions (Continued)** | |
| | by law and prescribed for Members who meet HPHC policies for enteral tube feedings.<br>10. Guest services.<br>11. Medical equipment, devices or supplies except as listed in this Benefit Handbook.<br>12. Medical services that are provided to Members who are confined or commited to jail, house of correction, prison, or custodial facility of the Department of Youth Services.<br>13. Reimbursement for travel expenses.<br>14. Services for non-Members.<br>15. Services for which no charge would be made in the absence of insurance.<br>16. Services provided under an individualized education program (IEP), including any services provided under an IEP that are delivered by school personnel or any services provided under an IEP purchased from a contractor or vendor.<br>17. Services for which no coverage is provided in this Benefit Handbook, Schedule of Benefits or Prescription Drug Brochure.<br>18. Services that are not Medically Necessary.<br>19. Taxes or governmental assessments on services or supplies.<br>20. Transportation , except for emergency ambulance transport, and non-emergency medical transport needed for transfer between hospitals or other covered health care facilities or from a covered facility to your home when Medically Necessary.<br>21. Voice modification surgery, except when Medically Necessary for gender affirming services.<br>22. The following products and services:<br>• Air conditioners, air purifiers and filters, dehumidifiers and humidifiers.<br>• Car seats.<br>• Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners.<br>• Electric scooters.<br>• Exercise equipment.<br>• Home modifications including but not limited to elevators, handrails and ramps.<br>• Hot tubs, jacuzzis, saunas or whirlpools.<br>• Mattresses.<br>• Medical alert systems.<br>• Motorized beds.<br>• Pillows.<br>• Power-operated vehicles.<br>• Stair lifts and stair glides.<br>• Strollers.<br>• Safety equipment.<br>• Vehicle modifications including but not limited to van lifts. |

| Exclusion | Description |
|---|---|
| **All Other Exclusions (Continued)** | |
| | • Telephone.<br>• Television. |

# V. Reimbursement and Claims Procedures

The information in this section applies when you wish to file a claim or seek reimbursement following receipt of Covered Benefits. In most cases, you should not receive bills from Plan Providers.

If you receive a Surprise Bill, you are only responsible for the applicable Member Cost Sharing based on the Recognized Amount. HPHC will reimburse Non-Plan Providers at the Out-of-Network Rate unless otherwise agreed to by the Provider and HPHC. You will not be billed for any charges other than the applicable Member Cost Sharing based on the Recognized Amount. You are not responsible, and a Non-Plan Provider cannot bill you, for:

- Amounts in excess of your Member Cost Sharing, based on the Recognized Amount, for non-emergency ancillary Covered Benefits received at certain In-network facilities by a Non-Plan Provider.
- Amounts in excess of your Member Cost Sharing, based on the Recognized Amount, for non-emergency, non-ancillary Covered Benefits received at certain In-network facilities from a Non-Plan Provider who has not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act.
- Amounts in excess of your Member Cost Sharing, based on the Recognized Amount, for Covered Benefits that are Medically Emergency Services provided by a Non-Plan Provider.
- Amounts in excess of your applicable Member Cost Sharing, based on the rates that would apply if the service was provided by a Plan Provider, for Covered Benefits that are air ambulance services provided by a Non-Plan Provider.

If you have any questions, call Member Services at **1-877-907-4742**.

## A. HOW TO FILE A CLAIM (PROOF OF LOSS)

Proof of loss is administered under this Handbook by filing a claim on an HPHC claim form. Such forms may be obtained by calling Member Services at **1-877-907-4742**.

Standard health care industry claim forms, known as the CMS 1500 and the UB04 will also be accepted. Such forms are also available at most hospitals and physician's offices. In order to be paid by HPHC, all claims must be filed in writing or electronically. (Providers should contact HPHC for instructions concerning electronic filing.) Claims for services must be submitted to the following addresses:

**Pharmacy Claims:**

**OptumRx**
**Manual Claims**
**P.O. Box 650334**
**Dallas, TX 75265–0334**

**All Other Claims:**

**HPHC Claims**
**P.O. Box 699183**
**Quincy, MA 02269–9183**

If you request a claim form from HPHC's Member Services Department, one will be provided to you within 15 days.

**Please Note:** Prior Approval is required to receive full coverage for certain services. Please see section *I.F. PRIOR APPROVAL* for more information on these requirements. For services that require Prior Approval from HPHC, please have your Provider call **1-800-708-4414**.

## B. REIMBURSEMENT FOR BILLS YOU PAY

To obtain reimbursement for a bill you have paid, other than for pharmacy items, you must submit a health care reimbursement claim form with the Provider or facility information. A legible claim form from the Provider or facility that provided your care may also be included but is not required. The health care reimbursement claim form must include all the following information:

- The Member's full name and address
- The Member's date of birth
- The Member's Plan ID number (on the front of the Member's Plan ID card)
- The Member's signature
- The name and address of the person or facility providing the services for which a claim is made and their Tax Identification Number (TIN) or National Provider Identification (NPI) number
- The Member's diagnosis description, diagnosis code or ICD 10 code
- The date the service was rendered
- The CPT code (or a brief description of the illness or injury) for which payment is sought

- The amount of the Provider's charge
- Proof that you have paid the bill (if reimbursement is sought)
- Other insurance information

**Important Notice:** We may need more information for some claims. If you have any questions about claims, call Member Services at **1-877-907-4742**.

A health care reimbursement claim form can be obtained online at **www.harvardpilgrim.org** or by calling Member Services at **1-877-907-4742**.

**1. International Claims**
If you are requesting reimbursement for services received while outside of the United States, you must submit a health care reimbursement claim form along with an itemized bill and proof of payment. We may also require you to provide additional documentation, including, but not limited to: (1) records from financial institutions clearly demonstrating that you have paid for the services that are the subject of the claim, (2) the source of funds used for payment; and (3) an English translated description of the services received.

**2. Pharmacy Claims**
To obtain reimbursement for pharmacy bills you have paid, you must submit a Prescription Claim Form. The form can be obtained online at **www.harvardpilgrim.org** or by calling Member Services at **1-877-907-4742**.

In addition to the Prescription Claim Form you must send a drug store receipt showing the items for which reimbursement is requested.

The following information must be on the Prescription Claim Form:

- The Member's name and Plan ID number
- The name of the drug or medical supply
- The quantity
- The number of days supply of the medication provided
- The date the prescription was filled
- The prescribing Provider's name
- The pharmacy name and address
- The amount you paid

**Important Notice:** Please see your Prescription Drug Brochure for more information.

If you have a question regarding your reimbursement, you should contact Member Services at **1-877-907-4742**.

## C. TIME LIMITS ON FILING CLAIMS

To be eligible for payment, we must receive claims within one year of the date care was received.

Failure to file claims in a timely manner as provided in this Section may result in denial of benefits.

Claims will be reviewed within 45 days of the receipt, unless it is a Surprise Bill. A claim for a Surprise Bill will be reviewed within 30 days of receipt. If a claim cannot be paid within that time, HPHC Insurance Company will either inform the Member:

a Of any additional documentation necessary for payment; or

b That the claim is denied, in whole or in part, and the reasons for denial.

## D. PAYMENT LIMITS

We limit the amount we will pay for services that are not rendered by Plan Providers. The maximum amount we will pay for services by Non-Plan Providers will be based on the Allowed Amount, unless it is a Surprise Bill. If a service is provided by a Non-Plan Provider, you are responsible for any amount in excess of the Allowed Amount, unless it is a Surprise Bill.

✔ FOR EXAMPLE: If the Allowed Amount is $1,000 and the applicable Member Cost Sharing for the service is 20% Coinsurance, the maximum amount we will pay is $800.

## E. NOTICE OF CLAIM

The Member is not required to give notice to HPHC prior to the filing of a claim, except for the Prior Approval requirements applicable to certain services. Please see section *I.F. PRIOR APPROVAL* for more information.

## F. MISCELLANEOUS CLAIMS PROVISIONS

Generally benefits will be paid to the Member who received the services for which a claim is made or directly to the health care Provider whose charge is the basis for the claim.

HPHC will have the right to require that a Member for whom a claim is made be examined by a physician as often as may be reasonably necessary to determine HPHC's liability for the payment of benefits under this Handbook. HPHC will also have a right, where not prohibited by law, to have an autopsy performed. Any such examination or autopsy will be conducted by a licensed physician chosen by HPHC and at its expense.

Any payment by HPHC in accordance with the terms of this Handbook will discharge HPHC from all further liability to the extent of such payment.

# VI. Appeals and Complaints

This section explains how we process appeals and complaints. It explains your options if an appeal is denied.

## A. ABOUT OUR APPEAL AND COMPLAINT PROCEDURES

### What are "Appeals" and "Complaints"?

- An appeal may be filed when coverage is denied. This includes either:
  - the denial of a health service you requested; or
  - the denial of payment for a health service you already received.
- A complaint may be filed when you have an issue with our actions or our services. (For a denial of coverage, you file an appeal not a complaint.)

Please file both appeals and complaints at the addresses or telephone numbers listed below.

#### 1. Member Representation

You may authorize, in writing, an individual to represent you, Your representative may file an appeal or complaint for you. Any notice will be sent to your representative upon request.

Below are examples of who you might chose to represent you:

- guardian,
- conservator,
- agent under a power of attorney,
- health care agent under a health care proxy,
- family member, or
- any other person appointed in writing to represent you.

We may ask you to document that the person chosen meets one of the above criteria.

#### 2. Report on Appeals and Complaints

We will file an annual report on appeals and complaints with the Office of Patient Protection. The report filed for the prior year will be available to you upon request. You can get it from the Member Services Department. See the address and telephone number listed in section *VI.B. HOW TO FILE AN APPEAL* below.

#### 3. Membership Required for Coverage

To be eligible for coverage, you must be enrolled under the Plan on the date a service is received. An appeal decision approving coverage will not be valid for services received after membership ends. However, payment may be made after membership ends for services received while you were still a Plan Member.

## B. HOW TO FILE AN APPEAL

Any appeal may be filed:

- in person,
- by mail,
- by fax,
- by telephone, and
- electronically via the secure online member portal.

Appeals should be submitted to:

**HPHC Appeals and Grievances Department**
**1 Wellness Way**
**Canton, MA 02021**
**Telephone: 1-877-907-4742**
**Fax: 1-617-509-3085**
**www.harvardpilgrim.org**

#### 1. Time Limit for Filing Appeals

An appeal must be filed within 180 days of the date a service, or payment for a service, when denied.

#### 2. Appeals Involving Medical Necessity Determinations

Special rights apply to appeals that involve a Medical Necessity determination. These appeals could involve a decision that a service:

- is not Medically Necessary.
- is not being provided in an appropriate health care setting or level of care.
- is not effective for treatment of the Member's condition.
- is Experimental, Unproven, or Investigational.

(These include the right to appeal to an external review organization. These organizations are under contract with the Office of Patient Protection. The external review process is summarized below. See section *VI.E. WHAT YOU MAY DO IF YOUR APPEAL IS DENIED*.

#### 3. The Office of Patient Protection

The Office of Patient Protection is the agency that enforces Massachusetts laws concerning managed care

grievance rights. They administer appeals to external review organizations. The Office of Patient Protection also:

- enforces health care standards for managed care organizations,
- answers questions of consumers about managed care, and
- monitors quality-related health insurance information relating to managed care practices.

The Office of Patient Protection can be reached at:

**Health Policy Commission**
**Office of Patient Protection**
**50 Milk Street, 8th Floor**
**Boston, MA 02109**
**Telephone: 1-800-436-7757**
**Fax: 1-617-624-5046**
**HPC-OPP@state.ma.us**
**http://www.masshpc.gov/OPP**

## C. THE APPEAL PROCESS

Our internal appeal process is available if you are denied coverage. This includes either:

- the denial of a health service you seek, or
- the denial of payment for a health service you have received.

After an appeal is filed, we assign an Appeals and Grievances Analyst. This analyst will be responsible for your appeal during the appeal process.

### 1. Acknowledgment of Appeals

Appeals will be acknowledged in writing within 15 days of receipt. This time limit may be extended by written mutual agreement between you and HPHC.

### 2. Release of Medical Records

Any appeal that requires the review of medical information must include a signed authorization. This allows Protected Health Information (PHI) to be released or obtained. This form must be signed and dated by you or your authorized representative. (Proof as the authorized representative, must also be provided). If authorization is not provided a blank form will be sent to you or your representative. We must receive a signed authorization to release or obtain PHI within 30 days of the date your appeal is received. If this is not received, we may issue a decision based on the information already in the file.

### 3. Time Limit for Processing Appeals

A written appeal decision will be sent to you by certified or registered mail. This will be sent within 30 days of receipt of the appeal. The time limit may be extended by mutual agreement between you and HPHC. Any extension will not be more than 30 days from the date of the agreement. Any such agreement must be made in writing. We may not extend the review period for an appeal if a service has been continued pending an appeal.

When the appeal requires review of medical information, the date of receipt will be the date a signed authorization to release or obtain PHI is received. No appeal will be deemed received until it is received at the appropriate address or phone number. The address and phone number are listed in section *VI.B. HOW TO FILE AN APPEAL* above.

If we do not act on an appeal within 30 days plus any extension of time mutually agreed upon in writing by the Member and us, the appeal will be deemed to be resolved in favor of the Member.

### 4. Medical Records and Information

When the appeal requires review of medical information, the date of receipt will be the date a signed authorization to release or obtain PHI is received. No appeal will be deemed received until it is received at the appropriate address or phone number. The address and phone number are listed in section *VI.B. HOW TO FILE AN APPEAL* above.

### 5. The Appeal Process

We will review, research and decide an appeal within the applicable time limit. See section *3. Time Limit for Processing Appeals* above.

The Appeals and Grievances Analyst will investigate the appeal. The analyst will let you know if additional information is needed. This information may include:

- medical records,
- statements from doctors, and
- bills and receipts for services you received.

You may also provide us with any written comments, documents, records or other information related to the claim.

Appeals that involve Medical Necessity decisions will be reviewed by a health care professional. This reviewer will be a health care professional who:

- is in active practice.
- is in the same or similar specialty as the medical specialty that treats the condition in your appeal.
- was not involved in any prior decision on your appeal

- is not the subordinate of any person who took part in a prioe decision about your appeal.

We will make a decision following the investigation and review of the appeal. We will consider the following review criteria when making our decision:

- the benefits, terms and conditions of coverage stated in your EOC,
- the views of medical professionals who have cared for you,
- the views of any specialist who has reviewed the appeal,
- any relevant records or other documents you provided, and
- any other relevant information available to us.

Our appeal decision will be sent to you in writing. The decision will:

- specify the information considered in your appeal;
- explain the basis for the decision; and
- point out the plan provisions that are the basis for the decision.

iIf coverage is denied based on Medical Necessity, the appeal decision will state:

- the specific information upon which the decision was based. This includes clinical practice and review criteria information relied on to make the decision.
- your presenting symptoms or condition, diagnosis and treatment interventions.
- the specific reasons the medical evidence fails to meet the relevant medical review criteria.
- any alternative treatment option we cover.

The decision will also include other options available for further review of the appeal. These options are described in section *VI.E. WHAT YOU MAY DO IF YOUR APPEAL IS DENIED*.

No one involved in the initial decision to deny a claim will make a decision in the appeal process. You have the right to receive, free of charge, all documents, records, or other information related to the initial denial and appeal.

## D. THE EXPEDITED APPEAL PROCESS

### 1. Expedited Appeals Process

You may obtain expedited review of certain types of appeals. An expedited appeal may be requested if we deny coverage for health services involving:

- continued hospital care,
- care that a physician certifies is required to prevent serious harm, or
- a Member with a terminal illness.

An expedited appeal will not be granted to review a termination or reduction in coverage resulting from:

- a benefit limit or cost sharing provision of this Handbook or
- the termination of membership.

Members may request an expedited appeal by phone or in writing at the following phone number or address:

**HPHC Appeals and Grievances Department**
**Harvard Pilgrim Health Care**
**1 Wellness Way**
**Canton, MA 02021**
**1-877-907-4742**
**Fax: 1-617-509-3085**

We will make a decision of an expedited appeal within 72 hours from receipt of the appeal. The time limit is specified below. If we do not act on an expedited appeal within the time limits stated, plus any extension of time as agreed to in writing, the appeal will be deemed to be resolved in your favor. Our decision will be sent to you in writing.

You may file an expedited appeal with HPHC, while also filing a request for expedited external review with the Office of Patient Protection. The filings can be done at the same time. You do not have to wait until HPHC completes your expedited appeal to file for expedited external review. See Section *VI.E. WHAT YOU MAY DO IF YOUR APPEAL IS DENIED*, "External Review" for more information.

You may obtain an expedited appeal for the following reasons and procedures::

#### i. Hospital Discharge

A Member who is an inpatient in a hospital will be provided with an expedited review of any action by us to terminate or reduce coverage for continued hospital care based upon the medical necessity of the hospitalization or the services provided. Any such appeal will be decided prior to the termination or reduction of coverage for the Member's hospital stay. Coverage for services will be continued through the completion of the appeals process. We will provide the Member with written notification of the appeal decision prior to discharge from a hospital.

#### ii. Services or Durable Medical Equipment Required to Prevent Serious Harm

An expedited review will be provided for appeals for services or durable medical equipment that, if not

immediately provided, could result in serious harm to the Member. "Serious harm" means circumstances that could (1) jeopardize the life or health of the Member, (2) jeopardize the ability of the Member to regain maximum function, or (3) result in severe pain that cannot be adequately managed without the care or treatment requested.

An expedited review will be provided in any case in which we have denied coverage for a service or durable medical equipment if the physician recommending the treatment or durable medical equipment provides us with a written certification stating that:

a) The service or durable medical equipment is Medically Necessary;

b) A denial of coverage for the service or durable medical equipment would create a substantial risk of serious harm to the Member; and

c) The risk of serious harm is so immediate that the provision of the services or durable medical equipment should not await the outcome of the normal appeal process.

Any such certification must contain the name, address and telephone number of the certifying physician and his or her signature. Certifications may be delivered in person, by mail or by fax at the addresses and telephone numbers listed above in this subsection. Upon receipt of a proper certification, HPHC will review the denial of coverage and provide the Member with notice of the decision within 48 hours. A decision may take place earlier than 48 hours for durable medical equipment if (1) a request for the early reversal is included in the certification and (2) the physician's certification includes specific facts indicating that immediate and severe harm to the Member that will result from a 48-hour delay.

#### iii. Member with a Terminal Illness

If a Member with a terminal illness files an appeal of a denial of coverage, a decision will be made by us within 5 business days of receipt of the appeal. A terminal illness is an illness that is likely to cause death within 6 months.

#### 2. Continuation of Services Pending Expedited Appeal

You may file an expedited appeal related to termination or reduction of coverage for ongoing treatment. In this case, coverage will be continued through the completion of our expedited appeal process if:

a) We authorized the service when it began.

b) We did not terminate or reduce the service due to a benefit limit under your EOC.

c) You are, and continue to be, a duly enrolled Member under this Handbook.

d) The appeal is filed on a timely basis, based on the course of treatment.

#### 3. Expedited Appeals Decision

We will notify you of the decision in writing. This will be by certified/registered mail or by any electronic means you agreed to. Notification will be made within 72 hours from receipt of your request for expedited review. When a decision is made to deny the coverage requested, it will include:

a) A statement of any medical and scientific reasons for the denial; and

b) A description of any relevant alternative treatment, services, or supplies covered by us; and

c) A statement that you may request a meeting with our review committee to reconsider the denial. The meeting will be held within 10 days of request. The treating physician may request that it be held earlier. In such event, the meeting will be held within 5 business days. At the meeting, you and the committee will review the information previously provided in response to your appeal. The review committee has the authority to approve or deny the appeal. The review committee's decision will be our final decision.

## E. WHAT YOU MAY DO IF YOUR APPEAL IS DENIED

If you disagree with the appeal decision, you may have options for further review. These options may include:

- reconsideration of appeals that involve a Medical Necessity determination (as described in *VI.B. HOW TO FILE AN APPEAL*) by our review committee, or
- external review by an independent organization appointed by the Office of Patient Protection.

Below is a summary of these options.

### a. Reconsideration by the Plan

If you disagree with a decision involving a Medical Necessity determination, you may request reconsideration. This can be done if there is additional clinical information that hasn't previously been reviewed by HPHC. You must request reconsideration within 15 days of the date of our denial letter.

Reconsideration is not available for the following types of appeals:

- Decisions involving a benefit limitation where the limit is stated in the EOC,
- Decisions involving excluded services, except Experimental, Unproven, or Investigational services, and
- Decisions concerning Member Cost Sharing requirements.

Our reconsideration process is voluntary and optional. You may request reconsideration before or after seeking any other dispute resolution process. The other processes are described below. The only exception is for appeals that have been accepted by the Office of Patient Protection for external review. For example, you may:

- request reconsideration of an appeal before seeking external review from the Office of Patient Protection.
- go directly to external review.
- request reconsideration, if the Office of Patient Protection has decided that an appeal is not eligible for external review.

We will not reconsider an appeal that has been accepted for external review by the Office of Patient Protection.

Reconsideration by HPHC will not affect your right to any other benefits. On reconsideration, HPHC will make an impartial evaluation of your appeal. This evaluation is based on the review criteria in "The Formal Appeal Process," above. It is also evaluated without deference to any prior decisions made on the claim. HPHC will provide you with a written decision of the review.

We will not assert that you have failed to exhaust administrative remedies because you have chosen not to seek reconsideration of an appeal that has been denied under the formal appeal process. We also agree that any statute of limitations or defense based on timeliness is tolled during the time period in which a request for reconsideration is pending. No fees or costs will be charged for reconsidering an appeal decision.

### b. External Review

If you disagree with a final appeal decision involving a Medical Necessity determination, you may request external review by an independent organization. Independent organizations are under contract with the Office of Patient Protection. A written request for external review must be filed with the Office of Patient Protection. This must be done within 4 months of receipt of the written notice of our appeal decision.

A copy of the external review form will be enclosed with your notice from us of the decision to deny your appeal.

A request for an external review must meet the following requirements:

1) The request must be submitted on the Office of Patient Protection's application form called, "Request for Independent External Review of a Health Insurance Grievance." A copy of this form is included with the denial letter. You may also get a form by:
   - calling Member Services at **1-877-907-4742**.
   - calling the Office of Patient Protection at **1-800-436-7757**.
   - downloading a copy from the Department's website at **http://www.masshpc.gov/OPP**.
2) The form must include your signature or the signature of your authorized representative, consenting to the release of medical information.
3) A copy of our final appeal decision must be enclosed.
4) A fee of $25 must be paid. The Office of Patient Protection may waive this fee for extreme financial hardship.

The Office of Patient Protection will screen requests for external review to determine whether external review can be granted. If the Office of Patient Protection determines that a request is eligible for external review, the appeal will be assigned to an external review agency. You (or your representative) and HPHC will be notified. The decision of the external review agency is binding. We must comply with the decision.

If the Office of Patient Protection determines that a request is not eligible for external review, you (or your representative) will be notified within 10 business days. For a request for expedited review, you will be notified within 72 hours.

The Office of Patient Protection may be reached at:

**Health Policy Commission**
**Office of Patient Protection**
**50 Milk Street, 8th Floor**
**Boston, MA 02109**
**Telephone: 1-800-436-7757**
**Fax: 1-617-624-5046**
**HPC-OPP@state.ma.us**
**http://www.masshpc.gov/OPP**

The Office of Patient Protection may arrange for an expedited external review. If you are not receiving inpatient service, a request must include a written certification from a physician that a delay in providing or continuing the health services that are the subject of the appeal decision would pose a serious and immediate threat to your health.

If the subject of an external review involves the termination of ongoing services, you may ask the external review panel to continue coverage for the service while the review is pending. Any request for continuation of coverage must be made before the end of the second business day following receipt of the final adverse decision.

The review panel may order the continuation of coverage if it finds termination of coverage may cause substantial harm to your health. The panel may also order the continuation of coverage for good cause. Any such continuation of coverage shall be at our expense regardless of the final external review determination.

**Note:** Payment disputes are not eligible for external review, except when the appeal is filed to determine if Surprise Bill protections are applicable.

## F. THE FORMAL COMPLAINT PROCEDURE

A complaint may be filed in person, by mail, by fax electronically via the secure online member portal, or by phone at the addresses or telephone numbers listed below. An Appeals and Grievances Analyst will investigate each complaint and respond in writing.

For all complaints call or write to:

**HPHC Appeals and Grievances Department**
**1 Wellness Way**
**Canton, MA 02021**
**Telephone: 1-877-907-4742**
**Fax: 1-617-509-3085**
**www.harvardpilgrim.org**

### 1. Documentation of Oral Complaints

If a complaint is filed by phone, a Member Services Representative will write a summary of the complaint and send it to the Appeals and Grievances Department.

### 2. Acknowledgment of Complaints

Written complaints will be acknowledged in writing within 15 days of receipt. This time limit may be extended by written mutual agreement between you and HPHC. No acknowledgment will be sent if a Member Services Representative has already sent you a summary of a complaint submitted by phone.

### 3. Release of Medical Records

Any complaint that requires the review of medical information must include a signed authorization. This allows PHI to be released or obtained. This form must be signed and dated by you or your authorized representative. (Proof as the authorized representative must also be provided). If authorization is not provided, a blank form will be sent to you or your representative. We must receive a signed authorization to release or obtain PHI within 30 days of the date your complaint is received. If this is not received, we may respond to the complaint based on the information already on file.

### 4. Time Limit for Responding to Complaints

A written response will be sent to you by certified or registered mail. This will be sent within 30 days of receipt of the complaint. This time limit may be extended by mutual agreement between you and HPHC. Any extension will not be more than 30 days from the date of the agreement. Any such agreement must be in writing.

When the complaint requires review of medical records, the date of receipt will be the date a signed authorization to release or obtain PHI is received. No complaint will be deemed received until it is received at the appropriate address or phone number. The address and phone number are listed in the section *VI.B. HOW TO FILE AN APPEAL*.

If we do not act on a complaint within 30 days, plus any extension of time as agreed upon in writing, the complaint will be deemed to be resolved in your favor.

### 5. Medical Records and Information

The Appeals and Grievances Analyst will work to get all information, including medical records. There is limited time available for processing complaints. You may be asked to help obtain any missing information. The time limit for response may be extended until the information can be obtained. If information is not received by the 15th day following the receipt of the authorization to release or obtain PHI, and no agreement can be reached on extending the response time limit, the Appeals and Grievances Analyst may respond to the complaint without the missing information.

# VII. Eligibility

This section describes eligibility rules under this Plan.

## A. MEMBER ELIGIBILITY

### 1. General Eligibility Requirements

To be a Subscriber under this Plan, you must:

a. be a resident of Massachusetts; and

b. not be seeking to replace an employer-sponsored health plan. This rule applies only if: (a) you are eligible for the employer plan; and (b) the employer plan provides coverage that is at least actuarially equivalent to minimum creditable coverage as defined by the Connector.

c. meet the following requirements:
   - agree to pay the monthly premium for coverage under the Plan;
   - not be entitled to or enrolled under Medicare Parts A, B or D.

If you have any questions about these requirements, you may call Member Services. HPHC reserves the right to request proof of residency at any time.

### 2. Dependent Eligibility

To be eligible as a Dependent, an individual must be one of the following:

a. The Subscriber's legal spouse. This means the same-sex or opposite-sex spouse of the Subscriber. The Subscriber and spouse must be in a legally valid marriage or civil union in a jurisdiction where such marriage or civil union is legal.

b. A child (including an adopted child) of the Subscriber or spouse of the Subscriber. Coverage is provided until the end of the month in which the child turns 26 or, if coverage is purchased through the Massachusetts Health Connector, until the end of the plan year in which the child turns 26.

c. A child (including an adopted child) of the Subscriber or Subscriber's spouse, age 26 years or older. The child must meet each of the following requirements:
   - is currently disabled;
   - lives either:
     - with the Subscriber or spouse,
     - in a licensed institution, or
     - in a group home; and
   - remains financially dependent on the Subscriber.

d. An unmarried child up to the age of 19 years, when either the Subscriber or Subscriber's spouse is the court appointed legal guardian. You must submit proof of guardianship to us prior to enrollment.

e. The unmarried child of an enrolled Dependent child of the Subscriber (or the Subscriber's enrolled spouse) until:
   - the child's parent is no longer an eligible Dependent, or
   - he child reaches age 19, whichever occurs first.

   Note: The enrolled Dependent parent must have legal custody of the child.

We may require proof of eligibility.

## B. EFFECTIVE DATE - NEW AND EXISTING DEPENDENTS

New Dependents may be added, and coverage will be effective as of the date of:

1. Marriage;
2. Birth;
3. Adoption;
4. Legal guardianship; or
5. The Subscriber becoming legally responsible for a Dependent's health care coverage.

Please see *VII.H. SPECIAL ENROLLMENT RIGHTS* for more information.

## C. EFFECTIVE DATE - ADOPTIVE DEPENDENTS

An adoptive child who has:

- been living with you, and for whom you have been receiving foster care payments, may be covered. Coverage will begin from the date the petition to adopt is filed.
- not been living with you may be covered. Coverage will begin on the date a licensed adoption agency places the child in your home for adoption.

We must be notified of the addition within 30 days of the effective date. The addition of new Dependents may change the Subscriber's membership from Individual Coverage to Family Coverage. If we are

not notified within 30 days of the effective date, Dependents may be added only on the Anniversary Date.

## D. CHANGE IN STATUS

You must inform us of all changes that affect eligibility. These changes include:

- address changes;
- marriage of a Dependent; and
- death of a Member.

If you purchased coverage through the Massachusetts' Health Insurance Marketplace (Massachusetts Health Connector), please see section *VII.I. MARKETPLACE MEMBERSHIP* below for more information.

## E. NEWBORN COVERAGE

A newborn infant of a Member or a newborn infant of a Dependent of a Member may be covered under the Plan. Coverage is from the moment of birth as required by law.

## F. HOW YOU'RE COVERED IF MEMBERSHIP BEGINS WHILE YOU'RE HOSPITALIZED

If your membership begins while you are hospitalized, coverage starts on the day membership is effective. All other terms and conditions of coverage under this Handbook will apply.

For In-Network coverage, you must be inpatient in an In-Network hospital.

If you are inpatient at an Out-of-Network hospital, you must notify HPHC by calling **1-800-708-4414** . See section *I.F. PRIOR APPROVAL* for more information.

## G. MEMBERS ELIGIBLE FOR MEDICARE

If you are entitled to Medicare benefits, you may apply for coverage under an HPHC plan for Medicare enrollees. You may contact Member Services for more information on applying for coverage under an HPHC Medicare plan.

## H. SPECIAL ENROLLMENT RIGHTS

A special enrollment period is a period during which an eligible individual or enrollee, or Dependent where applicable, experiences certain qualifying events or changes in eligibility that permit enrollment, or a change in enrollment, outside of the annual open enrollment period. Unless specifically stated otherwise, an eligible individual or enrollee, or Dependent where applicable, must select a plan within sixty (60) days of the following triggering events:

- Loss of minimum essential coverage or other qualifying health coverage*
- Change in primary place of living*
- Gains access to an individual coverage Health Reimbursement Account (ICHRA) or a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)*
- Change in eligibility for Marketplace coverage*
- Change in eligibility for the Premium Tax Credit or other cost sharing reductions*
- Gains a new Dependent or becomes a Dependent through marriage, birth, adoption or placement for adoption
- If you purchased coverage through the Marketplace, you may have additional special enrollment rights as determined by the Marketplace, including but not limited to
    - Change in eligibility for Medicaid or the Children's Health Insurance Program (CHIP)
    - Gaining or maintaining status as a member of a federally recognized tribe or a shareholder in an Alaska Native Corporation
    - Gains status as a U.S. citizen, national, or lawfully present individual
    - Meets eligibiltiy guidelines for Exceptional Circumstances as determined by the Marketplace

*An eligible individual or enrollee, or a Dependent where applicable, may have sixty (60) days before or after the triggering event to select a plan, or sixty-three (63) days before or after the triggering event if its due to a loss of minimum essential coverage or other qualifying health coverage.

These special enrollment rights comply with the Affordable Care Act (45 CFR 155.420) and Massachusetts state law (211 CMR 66.04).

If you need more information or have questions about special enrollment rights or special enrollment periods, call Member Services at **1-877-907-4742**

## I. MARKETPLACE MEMBERSHIP

Individuals purchasing coverage through Massachusetts' Health Insurance Marketplace must submit their application and enroll directly through the Massachusetts Health Connector. Administrative changes concerning coverage under this plan,

including changes in address, effective dates of coverage or termination of coverage must be made through the Massachusetts Health Connector.

# VIII. Premiums

## A. PREMIUM AMOUNT

You are responsible for paying the premium for Covered Benefits under the Policy. Your first premium payment is due the 1st of the month in order to begin your coverage. The following premium payments are due by the date stated on your invoice. This is generally the 1st day of the month. If you purchase coverage through the Massachusetts Health Connector, your premium is due on the 23rd day of the prior month.

Any misrepresentation or omission on your application may cause HPHC to change your premium retroactive back to the effective date. If the age of a Member under this Policy has been misstated, all amounts payable under the Policy shall be such as the premium paid that the Member would have purchased at the current age.

The rates provided are guaranteed for the twelve (12) month period following the 1st day of your effective date or renewal date, except that the premium will change when:

- you add or remove a Member from the Plan; or
- when you change your coverage.

Premium payments may be subject to change during the term of this Handbook based on the change of Subscriber address. Only Members for whom HPHC receives payment are entitled to covered benefits. Coverage is only for the period to which the payment applies.

## B. GRACE PERIOD

If you are a Subscriber who does not receive Advance Premium Tax Credit (APTC) assistance, this Policy has a 60 day grace period in which to pay your premium following the due date. This means that if any premium is not paid by the due date, it may be paid during the next 60 days. During the grace period, this Policy will remain in force. If the premium is not paid before the grace period ends, this Policy will lapse and be terminated as of the paid through date.

If you purchased coverage through the Massachusetts Connector, please contact the Connector for their grace period policy.

If you are a Subscriber who receives APTC assistance and at least one month's premium has been paid, HPHC will provide a grace period of at least three consecutive months (90 days). During the grace period HPHC must apply any payment received to the first billing cycle in which payment was delinquent and continue to collect the APTC from the federal government. If full premium is not received during the 90-day grace period, the policy will be terminated retroactively back to the last day of the first month of the 3 consecutive month grace period. HPHC must pay claims during the first month of the grace period but may pend claims in the second and third months subject to our right to cancel the Policy as described in this Policy. You will be liable for the premium payment due including those for the grace period and for any claims payments made for services incurred after the date through with the premium is paid.

## C. REINSTATEMENT

If your premium is not paid before the grace period ends, this Policy will lapse. Later acceptance of premium, along with a required reinstatement fee of up to $50, by HPHC or by an agent duly authorized by HPHC to accept such premium, without requiring an application for reinstatement, shall reinstate this Policy. If HPHC requires an application for reinstatement, it must be submitted to HPHC along with the required premium payment. Reinstatement of the Policy is subject to approval by HPHC. If the application is disapproved, this Policy will not be reinstated. If the application and the applicable premium payment are received by HPHC and the application is not disapproved in writing, this Policy will be reinstated upon the date of the receipt of the application. A reinstated Policy will provide coverage for services you incurred after the date of reinstatement. In all other respects your rights and the rights of HPHC will remain the same, subject to any provisions noted on or attached to the reinstated Policy.

# IX. Termination and Transfer to Other Coverage

## A. TERMINATION BY THE SUBSCRIBER

You may cancel your coverage under this Plan at any time. To cancel, you must contact HPHC. Your Plan will be cancelled the date we receive your request or on a future date of your choosing. Any premiums that were paid after your termination date will be sent back to you within 30 days of receiving notice of cancellation. Cancellation will not affect payment of Covered Benefits you receive while a member of the Plan.

If you are covered through the Massachusetts' Health Insurance Marketplace, you must contact the Health Insurance Marketplace (Massachusetts Connector) to cancel your policy. Termination may be processed for the same day that you notify the marketplace or a later date of your choosing.

## B. TERMINATION AND NONRENEWAL BY HPHC

This Plan is guaranteed renewable, as required by law, except as follows:

### 1. Termination for Nonpayment of Premium

HPHC may terminate this coverage for nonpayment of premium as stated in section *VIII. Premiums*. A Member's coverage will only be reinstated if HPHC terminated the member's coverage in error.

Members who purchased coverage directly through HPHC, may need to reapply. At its discretion, HPHC may reinstate this Policy without an application for reinstatement. This will require payment of all outstanding premium, along with a required reinstatement fee of up to $50.

Reinstatement rules for those members purchasing coverage through the Massachusetts Health Connector (the Connector) is governed by the Connector's reinstatement policies.

### 2. Termination for Cause

HPHC may end coverage with 30-days written notice to the Subscriber for any of the following reasons:

a. A Member has:
   - committed fraud;
   - misrepresented the eligibility of a Subscriber or Dependent for this Plan; or
   - misrepresented information needed to determine either the eligibility of a Member or a Member's entitlement to specific health benefits.

   It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company.

b. A Member has failed to comply in a material way with the requirements of the Plan. This includes, but is not limited to, relocation of the Subscriber outside of Massachusetts.

### 3. Non-Renewal for Cause

HPHC may refuse to renew this Agreement with written notice to the Subscriber. Notice will be sent at least 60 days prior to the Anniversary Date. Refusal may be for any of the reasons stated in (2) ("Termination for Cause"), above, or for any of the following reasons:

a. Failure at the time of renewal to meet eligibility requirements under this Benefit Handbook or Massachusetts law.

b. Failure to comply with HPHC's reasonable request for:
   - information, or
   - reasonable verification of information, in an application for coverage.

### 4. Termination Due to Product Discontinuance

HPHC may end coverage with written notice to the Subscriber. Notice will be sent at least 90 days prior to the date HPHC will cease to offer this Plan. If of termination is due to Plan discontinuance, the Subscriber may purchase other individual health coverage HPHC offers for which the Subscriber is eligible.

### 5. Termination Due to Withdrawal from Market

HPHC may end this Agreement with written notice to the Subscriber. Notice will be sent at least 180 days prior to the date HPHC ceases to offer coverage in the individual (nongroup) market in Massachusetts.

### 6. Acts of Abuse

HPHC may terminate or not renew a Member's coverage due to acts of physical or verbal abuse committed by a Member, which are unrelated to the Member's physical or mental condition, and pose a threat to:

- Providers,
- the Plan, or
- other Members.

In the event of termination, all benefits under this Agreement will end at midnight on the termination date.

## C. INDIVIDUAL HEALTH PLANS

We offer individual health plans for Massachusetts, Maine and New Hampshire residents. Coverage purchased as a individual may differ from the coverage under your previous Plan. You may enroll only in a plan offered in the state where you live. You must also satisfy all eligibility guidelines. Your state of residence will have specific rules about eligibility and coverage. If you have questions about individual health plan coverage please call the applicable number below.

**1. Massachusetts Residents:**
**1-866-229-8821** weekdays 8:30 a.m.- 5:00 p.m.

**2. Maine Residents:**
**1-855-354-4742** weekdays 8:30 a.m.- 5:00 p.m. .

**3. New Hampshire Residents:**
**1-844-213-1591** weekdays 8:30 a.m.- 5:00 p.m.

## D. MEMBERS ELIGIBLE FOR MEDICARE

Your membership may end because you are eligible for Medicare under conditions which federal law permits Medicare to be the primary payer for Medicare-covered services. If this happens, you may apply for coverage under an HPHC plan for Medicare enrollees. You may contact Member Services at **1-877-907-4742**for more information.

# X. When You Have Other Coverage

This section explains how Plan benefits will be paid when another company or individual must also pay for health services a Member has received. This can happen when:

- other insurance, in addition to this Plan, is available to pay for health services.
- a third party is legally responsible for a Member's injury or illness.

Nothing in this section should be interpreted as:

- providing coverage for any service or supply that is not expressly covered under the EOC; or
- increasing the level of coverage provided.

## A. BENEFITS IN THE EVENT OF OTHER INSURANCE

Benefits under the EOC will be coordinated to the extent permitted by law with other plans covering health benefits, including:

- motor vehicle insurance,
- medical payment policies,
- governmental benefits (including Medicare), and
- all Health Benefit Plans.

The term "Health Benefit Plan" means:

- all group HMO and other group prepaid health plans,
- Medical or Hospital Service Corporation plans,
- commercial health insurance, and
- self-insured health plans.

There is no coordination of benefits with Medicaid plans or with hospital indemnity benefits equal to less than $100 per day.

Coordination of benefits will be based on the Allowed Amount, or Recognized Amount. This applies for any service that is covered at least in part by any of the plans involved.

If benefits are provided in the form of services the reasonable value of these services will be used as the basis for coordination. This also applies if a provider of services is paid under a capitation arrangement.

No duplication in coverage of services will occur among plans.

For prescription drug claims, we will coordinate benefits pursuant to our secondary payor allowed amount in all cases.

A Member may be covered by two or more Health Benefit Plans. One will be "primary" and the other plan (or plans) will be "secondary." The benefits of the primary plan are determined:

- before those of secondary plan(s); and
- without considering the benefits of secondary plan(s).

The benefits of secondary plan(s)

- are determined after those of the primary plan; and
- may be reduced because of the primary plan's benefits.

Health Benefit Plans may contain provisions for the coordination of benefits. The rules below will determine which Health Benefit Plans are primary or secondary:

### 1. Employee/Dependent

The benefits of the plan that covers the person as an employee or Subscriber are determined first. The benefits of the plan that covers the person as a Dependent are determined second.

### 2. Dependent Children

#### i. Dependent Child Whose Parents Are Not Separated or Divorced

The order of benefits is determined as follows:

1) The benefits of the plan of the parent whose birthday falls earlier in a year are determined first. The benefits of the plan of the parent whose birthday falls later in that year are determined second.
2) Both parents may have the same birthday. The benefits of the plan that covered the parent longer are determined first. The benefits of the plan that covered the other parent for a shorter period of time are determined second.
3) The other plan may not have the rule described in (1) above. It may instead have a rule based on the gender of the parent. As a result, the plans may not agree on the order of benefits. In this case, the other plan will determine the order of benefits.

#### ii. Dependent Child/Separated or Divorced Parents

A court order may specify one of the parents as responsible for the health care benefits of the child.

Unless HPHC is aware of such court order, the order of benefits is determined as follows:

1) First the plan of the parent with custody of the child;
2) Then, the plan of the spouse of the parent with custody of the child;
3) Finally, the plan of the parent not having custody of the child.

**3. Active Employee or Retired or Laid-Off Employee**
The benefits of a plan that covers the person as an active employee or as a dependent of an active employee are determined first. The benefits of the plan that covers the person as an individual who is retired or laid off or as a dependent of that person are determined second.

**4. COBRA or State Continuation**
The benefits of a plan that covers the person as an employee, member, subscriber or retiree, or as a dependent thereof, are determined first. The benefits of the plan that covers the person as an individual under COBRA or other right to continuation of coverage under state or federal law are determined second.

**5. Longer/Shorter Length of Coverage**
None of the above rules may determine the order of benefits. In this case, the benefits of the plan that covered the employee, Member or Subscriber longer are determined first. The benefits of the plan that covered that person for the shorter time are determined second.

If you are covered by a health benefit plan that does not have provisions governing the coordination of benefits between plans, that plan will be the primary plan.

**Important Note:** Nothing in this Handbook shall be construed to limit HPHC's right to utilize any remedy provided by law to enforce its rights to coordination of benefits under this Handbook.

## B. PAYMENT WHEN HPHC COVERAGE IS PRIMARY OR SECONDARY

When HPHC is primary,

- HPHC is responsible for processing and paying claims for Covered Benefits first.
- coverage will be provided to the full extent of benefits available under the EOC.

When HPHC is secondary,

- HPHC is responsible for processing claims for Covered Benefits after the primary plan has issued a benefit determination.
- HPHC will first review the primary plan's benefit determination.
- HPHC will then pay or provide Covered Benefits as the secondary payor.
- HPHC's benefits will be reduced so that the total amount paid by all plans for a Covered Benefit will not exceed the amount payable under the EOC.
- HPHC may recover any payments made for services in excess of HPHC's liability as the secondary plan, either before or after payment by the primary plan.

## C. WORKERS' COMPENSATION/GOVERNMENT PROGRAMS

HPHC may have information that shows the services provided to you are covered under:

- Workers' Compensation,
- Employer's liability or other program of similar purpose, or
- by a federal, state or other government agency.

In this case, HPHC may hold payment for such services until a determination is made whether payment will be made by such program. If HPHC provides or pays for services for an illness or injury covered under another program of similar purpose, or by a federal, state or other government agency, HPHC will be entitled to recovery of its expenses. Recovery will be from the provider of services or the party or parties legally obligated to pay for such services.

## D. SUBROGATION AND REIMBURSEMENT

If you have an injury or illness legally caused by a third party, we have a right to be reimbursed by the third party for claims we pay for Covered Services you need. This is called subrogation.

Specifically:

- HPHC will be subrogated and succeed to all a Member's rights to recover against such third party (person or entity) 100% of the value of the services paid for or provided by the Plan.
- HPHC will have the right to seek such recovery from, among others,
  - the person or entity that caused the injury or illness;

  - his/her liability carrier; or
  - the Member's own auto insurance carrier; in cases of uninsured or underinsured motorist coverage.
- HPHC will also be entitled to recover from a Member 100% of the value of services provided or paid for by HPHC when a Member has been, or could be, reimbursed for the cost of care by another party. HPHC's recovery will be made from any recovery the Member receives from an insurance company or any third party.
- HPHC's right to recover 100% of the value of services paid for or provided by HPHC is not subject to reduction for a pro rata share of any attorney's fees incurred by the Member in seeking recovery from other persons or organizations.
- HPHC's right to 100% recovery shall apply even if a recovery the Member receives for the illness or injury is designated or described as being for injuries other than health care expenses.
- HPHC will have the right to take legal action, with or without the Member's consent, against any party to secure recovery of the value of services provided or paid for by HPHC for which such party is, or may be, liable.
- • The subrogation and recovery provisions in this section apply whether or not the Member recovering money is a minor.

## E. MEDICAL PAYMENT POLICIES

A Member may be entitled to coverage under the medical payment benefit of a boat, homeowners, hotel, restaurant, or other insurance policy, or the first $2,000 of Personal Injury Protection (PIP) coverage (or $8,000 for self-funded plans governed by ERISA). Such coverage shall become primary to the coverage under this Benefit Handbook for services rendered in connection with a covered loss under that policy.

A Member may be entitled to coverage under (1) a medical payment policy, or (2) Personal Injury Protection (PIP) coverage in excess of $2,000 (or $8,000 for self-funded plans governed by ERISA) Such coverage shall become secondary to the coverage under this Benefit Handbook for services rendered in connection with a covered loss under that policy. This shall be where, and only to the extent, the law requires the coverage under this Benefit Handbook to be primary.

The benefits under this Benefit Handbook shall not duplicate any benefits to which the Member is entitled under any medical payment policy or benefit. All sums payable for services provided under this Benefit Handbook to Members that are covered under any medical payment policy or benefit are payable to HPHC.

## F. MEMBER COOPERATION

You agree to cooperate with HPHC in exercising its rights of subrogation and coordination of benefits under this Handbook. Such cooperation will include, but not be limited to:

1) the provision of all information and documents requested by HPHC;
2) the execution of any instruments deemed necessary by HPHC to protect its rights;
3) the prompt assignment to HPHC of any monies received for services provided or paid for by HPHC; and
4) the prompt notification to HPHC of any instances that may give rise to HPHC's rights.

You further agree to do nothing to prejudice or interfere with HPHC's rights to subrogation or coordination of benefits.

If you fail to perform the obligations stated in this Subsection, you shall be rendered liable to HPHC for any expenses HPHC may incur, including reasonable attorneys fees, in enforcing its rights under this Handbook.

## G. HPHC'S RIGHTS

Nothing in this Handbook shall be construed to limit HPHC's right to utilize any remedy provided by law to enforce its rights to subrogation or coordination of benefits under this agreement.

## H. MEDICARE ELIGIBILITY

When a Subscriber or an enrolled Dependent reaches age 65, that person may become entitled to Medicare based on his or her age. That person may also become entitled to Medicare under age 65 due to disability or end stage renal disease. HPHC will pay benefits before Medicare:

- for you or your enrolled spouse, if you or your spouse is age 65 or older, if you are actively working and if your Employer has 20 or more employees;
- for you or your enrolled Dependent, for the first 30 months you or your Dependent is eligible for Medicare due to end stage renal disease; or

- for you or your enrolled Dependent,
  - if you are actively working,
  - you or your Dependent are eligible for Medicare under age 65 due to disability, and
  - your Employer has 100 or more employees.

HPHC may pay benefits **after** Medicare (including if you are eligible but not enrolled):

- if you are age 65 or older and are not actively working;
- if you are age 65 or older and your Employer has fewer than 20 employees;
- after the first 30 months you are eligible for Medicare due to end stage renal disease; or
- if you are eligible for Medicare under age 65 due to disability but are not actively working or are actively working for an Employer with fewer than 100 employees.

**Note:** When Medicare is primary due to End Stage Renal Disease (or would be primary if the Member were timely enrolled), the Plan will pay for Medicare Part B services only to the extent payments would exceed what would be payable by Medicare. The Plan will estimate the amount that would be payable by Medicare and pay secondary benefits accordingly. The Plan may apply the same terms when Medicare is primary due to age or disability (or would be primary if the Member were timely enrolled).

# XI. Plan Provisions and Responsibilities

## A. LIMITATION ON LEGAL ACTIONS

Members have two years to bring legal action against HPHC. This time period starts with the initial denial of any benefit.

## B. ACCESS TO INFORMATION

You agree that we may have access to the following (except where restricted by law):

- All health records and medical data from Providers of Covered Benefits.
- information concerning health coverage or claims from all providers of:
  - motor vehicle insurance.
  - medical payment policies.
  - home-owners' insurance.
  - all types of health benefit plans.
- HIV tests,
- substance use disorder rehabilitation,
- mental health treatment, and
- substance use disorder treatment.

We will comply with all laws that restrict access to special types of medical information. This includes, but is not limited to, data and records for:

## C. SAFEGUARDING CONFIDENTIALITY

HPHC values your privacy rights. HPHC is committed to safeguarding protected health information (PHI) and personal information (PI). Our Privacy and Security policies include:

- how HPHC administers privacy and security programs;
- staff training; and
- how PHI and PI can be used and disclosed.

We may collect, use, and disclose financial and medical information about you when doing business with you or others. We follow our privacy policies and state and federal laws. Our business partners administer your health care coverage on our behalf. We require our partners to protect your information in according to state and federal law.

For a copy of our Notice of Privacy Practices go to **www.harvardpilgrim.org** or call Member Services at **1-877-907-4742**.

## D. NOTICE

Member mailings are sent to your last address that we have on file. Mailings may include:

- notices;
- plan documents;
- invoices; and
- Activity Statements.

Be sure to let us know of an address change. This ensures mailings go to the right address. We are not responsible for mail you don't receive, if you have not sent an address change.

Notice to HPHC should be sent to:

**HPHC Member Services Department**
**1 Wellness Way**
**Canton, MA 02021**

See section *VI. Appeals and Complaints* for the address and phone numbers to file an appeal.

## E. MODIFICATION OF THIS HANDBOOK

We may amend the EOC. We will provide written notice to the Subscriber. Notice will be provided at least sixty (60) days prior to any material change in your Covered Benefits. Amendments do not require the consent of Members.

The EOC is the entire contract between you and the Plan. HPHC's responsibilities to you are only as stated in the EOC documents. They can only be modified in writing by an authorized Plan officer. No other action by us will waive or alter any part of the EOC. This includes non-enforcement of any benefit.

## F. OUR RELATIONSHIP WITH PLAN PROVIDERS

Separate agreements govern our relationship with Plan Providers. Plan Providers:

- are independent contractors.
- may not modify the EOC.
- may not create any obligation for HPHC.

We are not liable for their statements about the EOC. This includes their employees or agents.

Without notice to Members, we may:

- change our arrangements with service Providers; or

- add or remove Providers from the Plan.

## G. WELLNESS INCENTIVES

A Member may be able to receive incentives for taking part in health and wellness programs. Incentives may include reimbursement for certain fees you pay for taking part in:

- fitness programs;
- weight loss programs; or
- other wellness programs.

Receiving an incentive does not depend upon the outcome of the program. Go to **www.harvardpilgrim.org** for more information. See your EOC for any incentive amounts included with your Plan. For tax information, please consult with your employer or tax advisor.

## H. IN THE EVENT OF A MAJOR DISASTER

We will try to provide or arrange for services in the case of a major disaster. This might include war, riot, epidemic, public emergency, or natural disaster. Other causes include:

- the partial or complete destruction of our facility(ies).
- the disability of service providers.

We may not be able to provide or arrange services in a major disaster. We are not responsible for the costs or outcome of this inability.

## I. EVALUATION OF NEW TECHNOLOGY

We have a dedicated team of staff that evaluates new:

- diagnostics;
- testing;
- interventional treatment;
- therapeutics;
- medical/behavioral therapies;
- surgical procedures;
- medical devices and drugs; and
- new applications of the above.

The team manages an evidence-based evaluation process. This process recommends a status of (i) an accepted standard of care; or (ii) Experimental, Unproven, or Investigational. The team researches the safety and effectiveness of these new technologies by:

- reviewing published peer reviewed medical reports and literature,
- consulting with expert practitioners, and
- benchmarking.

The team makes recommendations to internal policy committees. These committees make final policy decisions for new technology coverage. The policy evaluation process includes:

- determining the FDA approval status of the device/product/drug in question;
- reviewing relevant clinical literature; and
- consulting actively practicing specialists about current practice standards.

## J. GOVERNING LAW

This Evidence of Coverage is governed by Massachusetts law.

## K. RESPONSIBILITIES OF HPHC INSURANCE COMPANY, INC.

The responsibilities of HPHC Insurance Company, Inc. (HPHC) to Members are only as stated in your EOC. The EOC can only be modified in writing by a duly authorized HPHC officer. No other action by HPHC will waive or alter any EOC provision. This includes not enforcing any coverage limitation.

## L. UTILIZATION REVIEW PROCEDURES

We use the following utilization review procedures to evaluate the Medical Necessity of certain services. We use clinical criteria to assure your care is clinically appropriate and cost-effective. This applies to both physical and mental health services.

- **Prospective Utilization Review (Prior Approval).** We review certain services before they are provided. This review determines if the proposed services meet Medical Necessity Guidelines. Services include:
  - elective inpatient admissions;
  - surgical day care;
  - outpatient/ambulatory procedures; and
  - Medical Drugs.

  Please see section *I.F. PRIOR APPROVAL* for more information. Prior Approval decisions are made within two working days of receiving all necessary information.

  **(1)** For notice of a decision to approve an admission, procedure or service:

- we will send notice in the HPHC provider portal within 24 hours of the decision.
- will send written notice to you and the Provider within two working days.

(2) For notice of a decision to deny or reduce benefits ("an adverse determination");

- we will call your Provider within 24 hours of the decision.
- we will send you and your Provider written or electronic notice within one working day after the call.

**Please Note:** Prior Approval is not required to receive Acute Treatment Services or Clinical Stabilization Services. This applies to both Plan Providers and Non-Plan Providers. For more information on using Non-Plan Providers, see your Out-of-Network Benefits. The terms "Acute Treatment Services" and "Clinical Stabilization Services" are defined in the Glossary.

- **Concurrent Utilization Review.** We review ongoing admissions for certain services. These reviews are to assure that the services provided meet Medical Necessity Guidelines. These services may be at:
  - hospitals, including acute care hospitals;
  - rehabilitation hospitals;
  - skilled nursing facilities;
  - skilled home health providers; and
  - behavioral health and substance use disorder treatment facilities.

  Concurrent review decisions are made within one working day of receiving all necessary information.

  For either a decision to approve or to deny additional services, we will call your Provider within 24 hours of the decision. We will send you and your Provider written or electronic notice within one working day. For ongoing services, coverage will continue without liability to you until you are notified of an adverse determination.

  Concurrent review includes active case management and discharge planning. Your Provider may also request these services.

- **Retrospective Utilization Review.** We may review services that were provided before Prior Approval was obtained. This includes review of emergency medical admissions for appropriate level of care.

To find the status of a clinical review decision call Member Services at **1-877-907-4742**.

For an adverse determination involving clinical review, your Provider may discuss your case with a physician reviewer. Your Provider may also ask us to reconsider our decision. We will reconsider a decision within one working day of your Provider's request. If the adverse determination is not reversed, you may appeal. Your appeal rights are described in section *VI. Appeals and Complaints*. Your right to appeal does not depend on making a request to reconsider our decision.

## M. QUALITY ASSURANCE PROGRAMS

HPHC has quality controls in place guided by the National Committee for Quality Assurance (NCQA). Our Quality Assurance programs are designed to ensure consistently excellent health plan services. Key Quality Assurance programs include:

- **Verifying Provider Credentials** - HPHC obtains, verifies, and assesses Plan Provider qualifications to provide care or services. This involves gathering evidence of licensure, education, training and other experience and/or qualifications.
- **Verifying Facility Credentials** - HPHC reviews and confirms licensures and certifications based on facility type.
- **Quality of Care Complaints** – HPHC follows a process to investigate, resolve and monitor Member complaints about care provided by a Plan Provider.
- **Evidence Based Practice** – HPHC compiles Medical Necessity Guidelines. These guidelines are based on the most current evidence-based standards. They provide an analytical framework for clinicians to evaluate and treat common health conditions.
- **Performance monitoring** – HPHC collects data to measure outcomes. This data is related to the Health Care Effectiveness Data and Information Set (HEDIS). It is used to monitor health care quality across various domains of evidence-based care and practice.
- **Quality program evaluation**- Annually HPHC develops, plans and implements initiatives to improve clinical service and quality. The Quality Program is documented, tracked and evaluated against milestones and objectives.

See and review the full program description at **https://www.harvardpilgrim.org/public/about-us/quality**.

## N. PROCEDURES USED TO EVALUATE EXPERIMENTAL/INVESTIGATIONAL DRUGS, DEVICES, OR TREATMENTS

We use a standard process to assess coverage questions and requests. These may come to us from internal or external sources. The process includes:

- Determing FDA approval status of the device, product, or drug in question;
- Reviewing relevant clinical literature; and
- Consulting with actively practicing specialists about current practice standards.

Decisions are developed into policy change recommendations. These are then sent to our management for review and final approval.

## O. PROCESS TO DEVELOP MEDICAL NECESSITY GUIDELINES AND UTILIZATION REVIEW CRITERIA

We use Medical Necessity Guidelines to make fair and consistent utilization management decisions. Medical Necessity Guidelines are developed according to NCQA standards. Guidelines are reviewed (revised, if needed) at least annually. Review may occur more often to include updates in practice standards. This process applies to criteria for both physical and mental health services.

For example, we use the nationally recognized InterQual criteria to review (i) elective surgical day procedures; and (ii) services provided in acute care hospitals. InterQual criteria are developed from current national standards of medical practice. Physicians and clinicians in academic medicine and all areas of active clinical practice provide input. InterQual criteria are reviewed and revised annually.

Medical Necessity Guidelines are also used to review other services. Physicians and other clinicians with relevant clinical expertise provide input. The process includes review of relevant clinical literature and local practice standards.

## P. NON-ASSIGNMENT OF BENEFITS

You may not assign or transfer your rights to benefits, monies, claims or causes of action provided under this Plan to:

- any person;
- health care provider;
- company; or
- other organization without written consent from HPHC.

You must have our written consent to assign any benefits, monies, claims, or causes of action that result from a benefits denial.

## Q. NEW TO MARKET DRUGS

New to market prescription drugs are reviewed by the Plan prior to coverage. This ensures that the drug is safe and effective. New to market drugs are reviewed by HPHC's:

- Medical Policy Department;
- New Technology Assessment Committee or Pharmacy Services Department; and
- the Pharmacy and Therapeutics Committee.

The review will take place within the first 180 days of their introduction to the market. Coverage for a new to market drug may apply Prior Approval and coverage limitations.

**Please Note:** Not all of our Plans provide coverage for outpatient prescription drugs through HPHC. Plan's that do not have coverage for outpatient prescription drugs, cover only Medical Drugs. If your Plan covers outpatient prescription drugs with us, see your prescription drug brochure for more details.

## R. DETERMINATION OF COVERED BENEFITS

We have the discretionary authority to:

- decide whether, and to what extent, you are eligible for Covered Benefits.
- interpret the terms of your EOC.

Our decisions and interpretations are final and binding.

## S. PAYMENT RECOVERY

We may determine that a mistake was made paying Plan benefits. We reserve the right to:

- recover such payments from the Provider or Member.
- offset later benefit payments to a Provider (regardless of payment source) or Member by any such overpayment amount.

# XII. MEMBER RIGHTS & RESPONSIBILITIES

You have a right to receive information about:

- HPHC, its services.
- Plan practitioners and Providers.
- Your rights and responsibilities.

You have a right:

- to privacy.
- to be treated with dignity and respect.
- to participate in decision-making regarding your health care.
- to a candid discussion of appropriate treatment options for your condition, regardless of cost or benefit coverage.
- to voice a complaint or appeal about HPHC or the care provided.
- to suggest changes to HPHC's members' rights and responsibilities policies.

You have a responsibility to:

- provide, to the extent possible, information that the Plan and Plan Providers need to manage your care.
- to follow your Provider's plans and instructions for care.
- to understand your health problems.
- to participate in developing mutually agreed upon treatment goals to manage your health.

**HPHC Insurance Company, Inc.**

**1 Wellness Way**
**Canton, MA 02021–1166**
**1–877–907–4742**
**www.harvardpilgrim.org**